The Unesco Courier

JANUARY 1982 - 5 French francs

The drug dilemma

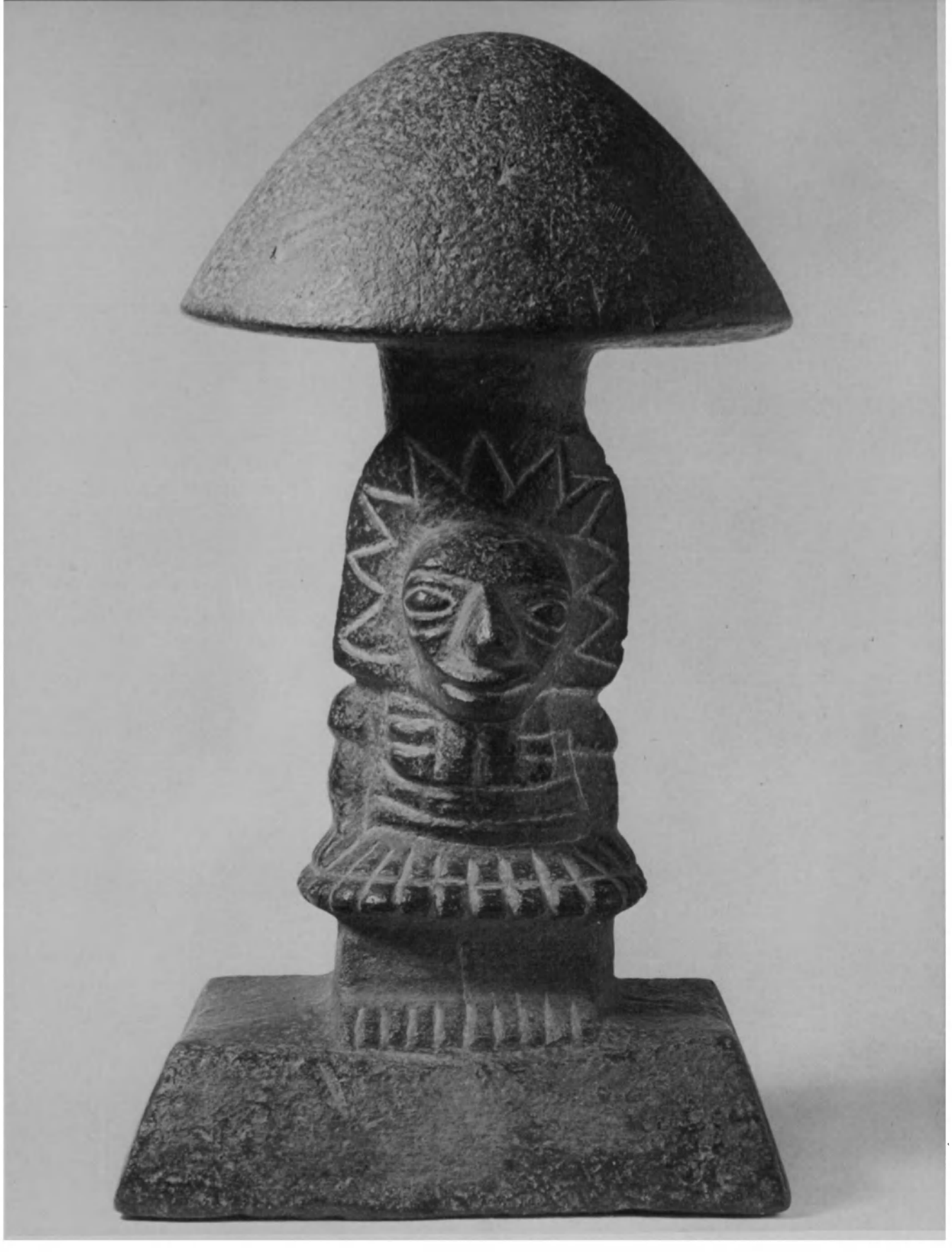

Photo Ernst Hahn © Rietbergmuseum, Zurich

TREASURES
OF
WORLD ART
169
El Salvador

Mayan mushroom stone

This stone figure (33.5 cm high) with its umbrella-like top dates from sometime between 300 BC and 200 AD. It is one of over 200 specimens unearthed in parts of central America where the ancient Maya culture flourished. Scholars tend to believe that the figures may represent mushroom effigies and, although their significance in ritual practice is unknown, attest to the sacred use of hallucinogenic mushrooms by the Mayas. Hallucinogenic mushrooms and plants played an important role in the religious rites of a number of ancient civilizations, their amazing effects on mental and physical functions being used to bring the partaker into communication with the spirit world. These substances, whose uncanny properties are only now being subjected to rigorous scientific study, are still held in awe and veneration today by some peoples bound to ancient traditions and ways of life.

The Unesco Courier

A window open on the world

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Cover

It is increasingly being recognized that there is no single prescription for the management of drug abuse and that each society must approach the question in a way suited to its own individuality. But it is also clear that in this field countries have much to learn from each other's experience. We hope that this issue of the *Unesco Courier,* which examines the issue of drug use and abuse in different parts of the world and the varied approaches to drug-related education and treatment which have evolved within a number of societies and cultures, will make a useful contribution to the sharing of some of this experience.

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Drug dependence: *'A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug.'*

World Health Organization

Photo Lawrence Schiller © Len Sirman Press, Geneva

For just over a decade, Unesco has been an active participant in the concerted United Nations action in the field of drug problems. During that period Unesco's main concerns have been the development of education, both in and out of school, aimed at both young people and adults, concerning problems associated with the use of drugs, including alcohol and tobacco, and the encouragement of research and the dissemination of its findings.

The United Nations body in charge of the co-ordination of the various aspects of drug problems is the Commission on Narcotic Drugs. Within the United Nations system, the United Nations Division of Narcotic Drugs and the International Narcotic Control Board are principally concerned with the international regulation and control of the production of drugs and trafficking in them. The United Nations Fund for Drug Abuse Control (UNFDAC), established in 1972, helps to fund the drug-related activities of the United Nations agencies. The World Health Organization (WHO) concentrates on epidemiological, biological and medical research and the treatment of drug users; the Food and Agriculture Organization (FAO) organizes programmes for the eradication of drug-providing plant cultivation and the installation of alternative cash crops; the International Labour Organisation (ILO) assists in the development of vocational and rehabilitational training at the place of work for former drug users.

In the article below we present findings of a Unesco survey of recent trends and developments in drug use and in preventive education in twenty industrialized countries. Other articles in this issue, which is entirely devoted to the drug question, include a United Nations dossier on the types of drugs under international control, which appears on page 25, and a series of texts based on an important new WHO study on "Drug Problems in the Socio-Cultural Context". These articles which appear on pages 13, 20, 30, 32 and 33 have been adapted for the *Unesco Courier* by Professor Griffith Edwards who is the co-editor, with Awni Arif, of the WHO study. They are presented in an introductory article on page 11 specially written for the *Unesco Courier* by Prof. Edwards.

Education and the drug dilemma

A Unesco survey

NOT long ago, education was virtually overlooked as an aid in preventing drug abuse. Confidence was vested in other means such as legal controls and the repression of traffic. Then, in the post-war years, changes in the pattern of drug abuse itself brought a belated recognition of the need to enlist education in efforts to grapple with the problem.

Much has happened since the first attempts to devise serious educational responses to the drug challenge. A more penetrating understanding of drug use in industrially developed countries and a certain wisdom gained through educational trial and error have made it possible to strengthen the bases and techniques of preventive education. No doubt its evolution will continue, for while some progress has been made many questions still remain unanswered.

As regards the central aim of preventive education, it seems apparent that there has been a shift of emphasis in a substantial number of countries. This change has has significant effects on approaches, programmes and methods. In the past the goal had often been to prevent or minimize all non-medical use of drugs. At its heart was the exhortation: don't use drugs. This is often still the stated aim. Experience now seems to demonstrate, however, that it is unrealistic, especially in societies that accept the virtually unrestricted consumption of alcohol and tobacco.

The view that there is much to be gained from working towards more attainable goals now seems to prevail among specialists. The report from Canada states, for example: "In the long term one must examine and decide upon reasonable objectives. It would appear that the elimination of drug use may be impossible; however, improvement in the individual's capacity to manage his use of drugs and to make reasonable choices based on factual knowledge about the effects of drug use may be possible".

The same point is made by the author of the report from the United Kingdom: "... on the basis of the evidence available from evaluations throughout the world, no known methods of drug education can be said to reduce drug use... demand-reduction is not an adequate basis for drug education. Drug education should, instead, be concerned to minimize the negative outcomes of drug use, to abolish unnecessary stigmatization and self-fulfilling prophecies: drug education should focus on promoting relatively safe patterns of drug use...".

Hardly any statement about preventive education is likely to win universal assent and the foregoing quotations are no exception. Nevertheless, on several fundamental matters there appears to be a large measure of agreement.

One of these is the role of information. At an earlier stage facts about drugs and their effects formed the core if not the entirety of many teaching programmes. This approach was grounded on the assumption that such knowledge would be sufficient to prevent young people from experimenting with or misusing drugs. Accordingly, attention was focused on substances, and the consequences of using them were often presented in a manner designed to shock, to arouse, fear and thereby to dissuade.

The confidence once placed in this approach has faded. "Information only for the sake of information can potentially lead to more harm than good", warns the report from Yugoslavia. A similar judgement is expressed in the report from Spain, which points out that the information provided may arouse curiosity or even justify drug use in the eyes of the young by presenting it as anti-social and as a form of contestation against the older generation and its values. In Norway, a study of teachers' attitudes

showed that, in their judgement, information alone was a weak basis for individual choices pertaining to drug use. The report from Australia states : "Information is considered to play an essential part in achieving the objectives of drug education, but is not sufficient of itself to change attitudes and behaviour". Similar views are expressed in most of the other reports.

AND yet the case concerning information is by no means closed. "We do not fear that giving information to innocents will evoke curiosity and thereby increase experimentation in youthful groups", says the report from Denmark. And a research project in Canada has yielded findings concerning the effects of the information approach which may give pause to its critics.

However, the tactic of using information about drugs to arouse fear is now generally rejected, usually on the grounds that it may make drugs attractive to the more self-destructive elements of high-risk groups.

The information approach has to a large extent given way to another. Taken as a whole the reports reveal a marked trend towards an approach which, while reserving a place for information, treats knowledge as only one of many components of preventive education. The substance-focused, information-giving approach is more and more subsumed in what is referred to in some of the reports as "affective education". Such education is directed towards the totality of the individual personality instead of merely the cognitive, intellectual part. The aim, like that stated in 1963 for temperance education in Finland, is the development of "a physically and psychologically healthy personality". As such it is relevant not only to high-risk students but to all students.

The affective approach is concerned with individuals in their specific social and cultural setting and with the interaction of personality and values in situations of decision-making about drug use. "It has been shown in our studies that it is of the utmost importance that the teachers use the *situation-centred approach",* says the report from Denmark.

Although the affective approach has now taken hold in many programmes, old-style preventive education continues alongside it or in combination with it. For example, the report from the United Kingdom notes that although national curriculum projects usually have rationales or philosophies that favour the affective approach, the project materials also tend to rely on a substance-focused, information-giving approach. The report adds that this mixture tends, in the classroom, to be translated into substance-focused discussion because both teachers and pupils are most drawn to the subject of drugs and their effects. The newer curricula are not being rigorously executed. "The muddle on the policy level", the author observes, "is being reproduced on the classroom level."

The affective approach requires the adoption of educational methods and techniques which will stimulate the students' interest and inyolve them as active partners in learning experiences. The trend towards the use of such methods is one which education in this field shares with education in general. Often referred to as "active" methods, they have proved to be especially useful in such areas as moral and civic education, where the formation of attitudes and patterns of behaviour is an objective.

The need to use methods of this kind seems now to be widely accepted. A few examples will serve to illustrate the generalization. Instructions on temperance and health education (which include preventive education) in Finland state: "Mere theoretical instruction is not adequate... Teaching is associated with children's everyday experiences... Pupil-centred methods of work are applied" (report from Finland).

An example of such pupil-centred methods comes from Sweden, where study often takes place in small groups and is organized largely by the pupils themselves. A lesson plan outlined in the report begins with discussion motivated by a film or some other element, continues with study by all pupils of a common syllabus combined with individual and group project work and concludes with students' reports and a discussion.

The report for Flemish-speaking Belgium, noting the role of dialogue, emphasizes the importance of having pupils explain how they perceive and experience the problem. A statement from Australia on the philosophy of its national drug education programme refers, in a list of teaching procedures, to debates, panel discussions, educational games, group discussions and committee work among other active methods.

VALUES-CLARIFICATION, role-playing, problem-solving and decision-making exercises are mentioned in a number of reports or the materials transmitted with them. These have become staple techniques of affective education in this field. Values-clarification, a process of choosing among alternatives after considering the consequences of each, assists in the formation of attitudes concerning drugs which will aid the individual to make decisions that are helpful to himself or herself and others. Thus, the technique often centres on situations involving a choice as to whether or not to accept particular opportunities for experimentation or use.

Role-playing helps students to understand problem situations or value conflicts through simulated experience and to empathize with people in positions that may be very different from their own. Decision-making, generally focused on individual problems and conflicts, and problem-solving, usually dealing with group problems, involve four essential steps: defining the problem or conflict; listing the possible choice or alternative ways of resolving the problem or conflict; investigating the consequences of each of the alternative resolutions, and choosing the alternative that is most satisfying to the individual or group.

Much of what has already been said about objectives, approaches and methods applies both to school education and out-of-school education. Thus, the aim in out-of-school education is now less commonly to stop non-medical use of drugs than to develop attitudes and patterns of behaviour that will minimize damage from drug use—what one report calls the "casualty-reduction approach"—and active methods such as those previously described are increasingly employed.

As regards educational materials, the resources of the countries surveyed here range from comparative indigence to abundance. In virtually all of them, however, there appears to have been a growth in the supply of materials of good quality in recent years.

For use in school education, in addition to the information included in textbooks for courses which serve as vehicles for drug education, auxiliary teaching aids are being produced in an increasing number of countries: illustrated booklets, workbooks and discussion guides for students; posters, films, videotapes and charts for classroom use; and guides, manuals and kits or packets for the teacher containing all the essentials for one or more lessons.

The flow of materials intended primarily (though not necessarily exclusively) for use outside the school is also increasing. Among them are information booklets, articles and advertisements in the press, periodicals, posters, stickers and radio and television programmes and "spots". While some of these are aimed at specific target groups, most are intended for the general public. The wisdom of disseminating certain kinds of drug information indiscriminately to the population as a whole has been questioned by some specialists on the grounds that it may do more harm than good. What is needed, according to the critics of this

method, is information and materials adapted to the characteristics and requirements of particular groups and distributed selectively.

Such targeted materials are now being produced in many countries for a variety of groups: children, young people, parents, workers, the elderly, various professional groups and others. Particularly noteworthy is the preponderant attention given in many countries to materials on alcohol and tobacco, a reflection of the fact that these substances are at the root of their most serious and widespread drug-use problems.

The method adopted in Finland illustrates not only the target-group principle but also an interesting non-prohibitive approach. In Finland, the State liquor monopoly, Alko, has a large programme of information aimed at consumers of alcohol. It distributes different kinds of material through appropriate channels (retail liquor shops, restaurants, sports organizations, driving schools, etc.) to specific groups. The goals are to restrain harmful consumption and to alter attitudes that favour over-indulgence. The position taken in the materials rests on four propositions: the best way to avoid problems is abstinence; long-term heavy drinking is always harmful; even small amounts in the wrong situations can be dangerous; alcohol can also have positive effects.

GENERAL guidelines for use in preparing materials have been issued in some countries. Here again one example, chosen because of the unusual circumstances from which the guidelines emerged, will serve as an illustration. In the United States in the late 1960s a probably unique problem of a materials glut arose. At that time, "a major industry emerged that revolved around one primary activity: producing and disseminating informational materials that dealt with the dangers of drug use. A conservative estimate in 1972 gauged the extent of the drug information business at $100 million a year. Ultimately the flood of information—and misinformation—itself became a cause for alarm".

A major review of existing materials in 1971 found most of them by far to be inaccurate or unsuitable for other reasons. In response to this finding the federal government declared a moratorium on the production of federally funded drug information materials. Later the moratorium was lifted when new guidelines had been issued.

These guidelines ensured audience identification and pre-testing of material. They excluded messages in which fear was the main deterrent or the way to use drugs was shown, and recommended general themes to be promoted.

Provisions for preventive education in school programmes vary considerably among the countries covered by the Unesco survey. At one end of the spectrum it is a compulsory part of the offical curriculum; at the other end, there is no specific provision for it and initiative is left largely to individual teachers. In some instances it is an extra-curricular activity. The range of differences is represented by the following examples.

Finland: Instructions on temperance education in primary and secondary curricula have been issued by the National Board of Schools since the early years of this century. Since 1967 teaching has been incorporated at the primary level (fifth to eighth grade) into a new subject called civics and citizenship. In the secondary school it is a part of hygiene and biology, with some teaching in other courses as well. The programme consists of two to six lessons a year.

Sweden: Teaching about alcohol, narcotics and tobacco was made compulsory at all levels by the curriculum adopted in 1967. It is given in various courses according to instructions drawn up by the National Board of Education.

Denmark: It is obligatory for all schools to offer preventive education from the sixth to the tenth grade. It is integrated into such courses as biology, social sciences and physical education.

Norway: Preventive education is an obligatory study area in curricula for students from ten to sixteen years of age. No specific number of hours is fixed for it.

Greece: Preventive education is integrated into different courses in the first, second and third years of secondary school.

Italy: Preventive education is provided in the framework of health education, which is considered to be part of the educational process as a whole and a responsibility of all teachers. It is explicity assigned to teachers of natural science and chemistry at the secondary level.

Federal Republic of Germany: Preventive education is included in curricula in all *Länder,* or States. Usually the subject is taken up repeatedly from about the seventh grade (pupils of 13 years) onward. New curricula for all grades, now being prepared by the Federal Centre for Health Education, will be completed during the next few years.

Yugoslavia: Programmes of preventive education include teaching in various compulsory and optional courses, lectures of a social character arranged by organizations such as the Red Cross and discussions in school clubs. As regards teaching, an example is provided by Serbia, where components of preventive education are incorporated into the subject "nature and society" in grades I to IV and in biology in grade VIII.

Australia: Preventive education programmes are authorized in schools in most States, but decisions concerning them are usually left to principals of individual schools.

Czechoslovakia: Teaching about alcohol and related problems is found sporadically in school programmes, and material on the dangers of smoking is included at every level. Teaching about other drugs is provided through extra-curricular projects.

France: Preventive education is not included in curricula. Information is provided to pupils at their request, notably in the "Life and Health" clubs which are found in many schools and which are concerned not only with this matter but also with other problems that preoccupy young people (e.g., the environment, sexuality).

There is no advocacy in the reports of a separate and identifiable course on drug-related problems. Instead, as the foregoing examples show, preventive education is nested in other courses, most often health education/hygiene with biology and social studies/civics next in the order of frequency. Other courses mentioned as vehicles include natural science, chemistry, religion, *moral laïque*, psychology, physical education, home economics, anthropology, history, environmental studies, sex education and languages.

IN addition to information on drug use and provision for preventive education, many of the reports comment upon the evolution of attitudes regarding drug use in general or the use of particular drugs. The changes described do not fall into patterns, either within or among countries, that permit generalizations of much significance.

Three observations do, however, seem justified:

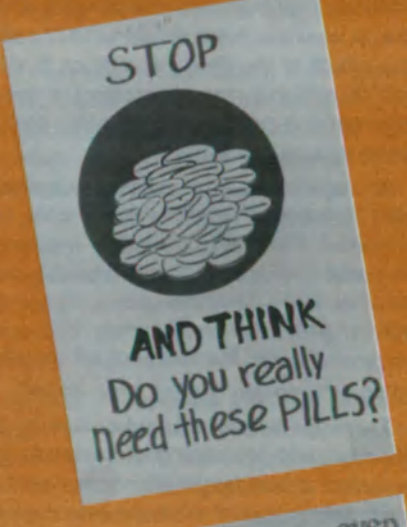
In some countries the public alarm of a decade ago over the "drug problem" seems to have subsided. The diminished concern probably results in part from a growing tendency to dedramatize the issue. In the United States, for example, the Director of the National Institute on Drug Abuse drew attention in 1979 to "the widespread public opinion which is, if not supportive, at least neutral about the harm of drug abuse". Another official document from that country refers to an "apparent increased tolerance of drug use".

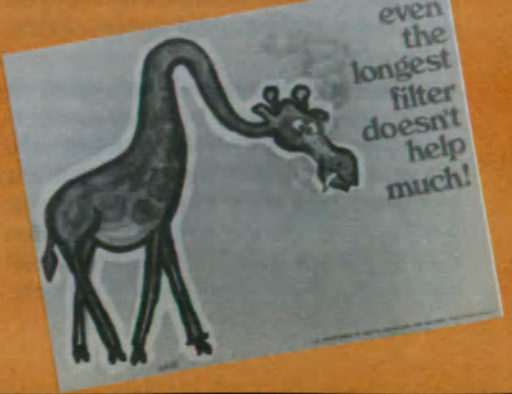
Acceptance of the use of certain illicit drugs appears to have increased. This is notably the case in some countries as regards cannabis (e.g., Canada, Denmark, the United States).

Resistance to the use of permitted drugs has increased in some countries. Thus, several reports note that adverse public attitudes are putting tobacco smokers on the defensive (in New Zealand, for example) and others indicate development of stronger opposition to the use of alcohol (as in Norway, where 15 to 20 per cent of the population advocate total abstinence).

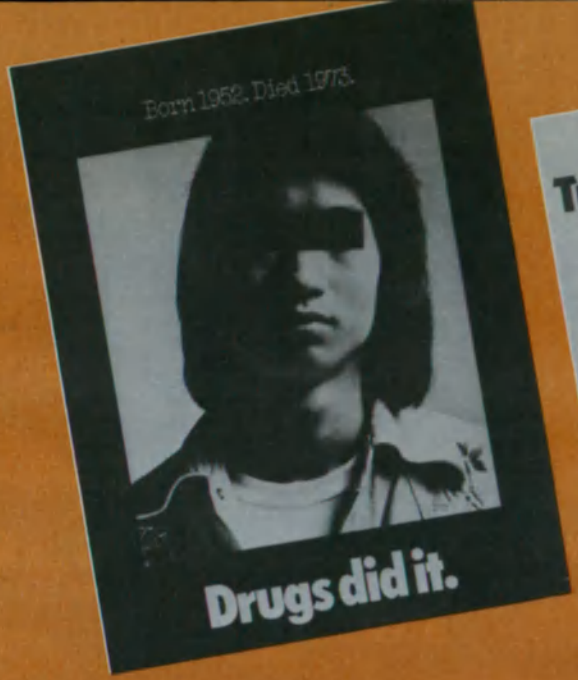
To what may these apparent fluctuations in attitudes be attributed? No doubt many factors which vary from country to country exert an influence. Among them certainly must be counted the content and tenor of information reaching the public through education and the mass media. ■

Posters against drugs





Posters © All rights reserved


Born 1952. Died 1973.
Drugs did it.

Turvallisuuttaajoteille

Välj nykterhet-det lönar sig.
Finlands Nykterhetsorganisationers Förbund

rahat ja henki!

sans tabac
prenons la vie
à pleins poumons

A PROUD
FUTURE –
DRUG
FREE

K(R)AMPF

КУРИШЬ-
СЕБЯ
ГУБИШЬ!

smoking...burns
INTERNATIONAL CONFERENCE
Tobacco and youth

TARTU PULMIIN
SELVIN PÄIN

A new approach to drug dependence

by Griffith Edwards

OVER the last decade or two "drug education" has been much in vogue as a way of meeting society's worry about illicit drug taking by young people. But in the broadest sense, who educates the educators? Put simply and challengingly—"Do you know what you are talking about?"

The teacher standing there with chalk and blackboard or the latest film strip at the ready, is of course only a metaphor: what we are really asking is whether laws and government policies on addiction, treatment programmes and prevention programmes, our reactions to drug use and our own use of drugs (alcohol and tobacco are drugs) are based on informed understanding or on frightened misconceptions.

Misconceptions, for instance, frequently include ideas such as that alcohol is not a drug, that drug taking is a problem that involves only young people, that one type of explanation can explain all drug taking, that a solution favoured in the West has the answers for the East, that we can "cure" societies', drug problems by ever more active customs and police action, that drug use inevitably means lurid degradation, that what is wrong is *simply* the drug, *simply* the individual, or *simply* society out of balance.

Let us, as it were, put the chalk down for a minute, and ask ourselves first of all what meanings and explanations we are really giving to this key word "addiction".

The word *addiction* by immediate reflex will in most people's minds conjure up images of something which is alien, unintelligible, and perhaps carrying with it a whiff of association with evil and enchantment. It is a word which invites fear, perhaps contempt, and certainly a suspension of cool analysis.

Today the nuances of meaning vary greatly between languages, and any international meeting on drug problems soon discovers that it is involved in a tangle of linguistics. There are languages where this word *addiction* has no precise translation, and other languages where there is no concept available which even remotely resembles this key term.

We find ourselves again discovering that words are not only our servants but also our masters: vocabulary shapes the way we think about things and (much more dangerously), the way we think about people.

Some years ago, in 1969, the World Health Organization promulgated the idea of *drug dependence* as an alternative concept to addiction. The new phrasing was certainly meant to be more than a mere synonym for the older term. What was implied was the need to recognize the fact that different types of drug can produce very varying types and degrees of reliance on their use, whereas the word *addiction* all too easily suggests an extreme and stereotyped picture, resembling perhaps that produced by heroin. Because of its brevity and its penetration of our ordinary language the word addiction is nevertheless still likely to remain in circulation for a long time—the word *addict* comes more naturally than the phrase *drug dependent person.*

But whether we designate compulsive drug taking as bad habit, addiction, or dependence, what is the essential *nature* of the thing we are talking about? There are a number of possible levels of explanation. The laboratory scientist will be interested in the neurochemistry and the influence of the drug on the transmission of nervous impulses, and the mechanisms which underlie tolerance and the withdrawal state. The psychologist will focus on addiction as learnt behaviour, the drug experience as reinforcing and conditioning of drug taking behaviour, or on the learning processes which came about from the relief of withdrawal symptoms by a further dose of the drug. And meanwhile the sociologist will seek to understand the social determinants of drug taking, the peer group pressures, and the nature of the environment which proposes drug taking. Being an addict is, he will argue, the assumption of a social role. The anthropologist will point out the symbolic meaning of the drug and will see the rituals and functions of drug taking as rooted in the individual's culture.

Which explanation is to have pre-eminence? There is an invitation here to a certain kind of chauvinism, with the pure scientist believing that only his sort of science can really put a finger on the absolute nature of addiction, and that truth can be reduced to the ultimates of the neuronal synapse: the social scientist may equally be tempted to claim that the neurosciences are crass and only work at a level which is absurdly remote from the social reality of "being an addict"—the electron microscope no matter how high-powered does not reveal the texture of the opium smoker's hillside village, or the street corners of the heroin addict's life. To put such different perspectives into positions of confrontation and rivalry is, however, unproductive.

The challenge which is issued by the attempt to understand drug taking and drug addiction goes wider though than the immediate question: it is the challenge to overcome a much more general habit in our thinking which favours one-dimensional explanations. It is in fact quite impossible to approach a whole understanding of why, for instance, the Andean peasant chews his coca leaves unless we are at one and the same time willing to make an effort to understand the pharmacological properties of cocaine, the psychological nature of the drug experience, the working conditions of that labourer, and the way that society regards coca chewing.

What a challenge! But this is not a position to be arrived at simply for the sake of abstract intellectual satisfaction, a sort of show-off intellectual conjuring trick. On the contrary, this is the needed basis for all manner of practical dealings. If we retreat to one-dimensional vision we will inevitably find ourselves trapped in ill-adapted policies and responses.

Having insisted on this need for an understanding which is balanced and integrated, it can probably now be seen that the worst errors of recent years have come from a tendency to neglect the social and cultural dimensions. A policy which attempts, for instance, to prevent urban heroin addiction by heavy police penalties for use or by lecturing school children on the evils and dangers of this substance, while ignoring the nature of life and the frustrations of opportunity in a shattered ghetto where being an addict gives comradeship, a sense of shared purpose and enterprise and a definition of self not otherwise easily available, is to embark on a response which is likely not only to be ineffective and costly but also to be cruel.

Addiction certainly matters, but we should also be much more attuned to thinking in terms of the actual pattern of problems which the individual or society is encountering where drugs are concerned—problems occurring singly or in clusters, and affecting health in its physical, psychological or social domains.

We started with the image of a speaker about to give his talk and very politely we asked him to pause a minute and define what he was talking about. In this complex area the business of understanding is never completed, but will be much aided by shared experience from many villages and streets. The articles which follow have that aim.

■ **Griffith Edwards**

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Patterns of drug use

To map in totality the astonishingly varied patchwork of drug use throughout the world would be a daunting task. But the following first-hand accounts by experts of nine different countries or regions provide us with a vivid insight into the nature and extent of the diversities. In each instance the author shows how drug use is only to be understood against the social and cultural background. Often today part of that background is people's sense of the rapidity of environmental change and the breakdown of the old rules, attitudes and ways of living—changes which are immediately reflected in altered patterns of drug use.

Reports from nine countries

THAILAND. Dr. V. Poshyachinda describes traditional use of opium by the Hmong, one of the northern hill tribes. There are well-formed attitudes and expectations which informally control the use of this drug.

A predominant reason for the use of opium is for treatment of physical ailments. Opium is also used for its tranquillizing and euphoric effect. Reactive depression from the death of a loved one or from loss of livestock or crops may lead some to opium use. Thirdly, this drug is a means of recreation. At social gatherings in the village, tea, alcohol and tobacco are used as well as opium. The Hmong have a rather rigid custom of not allowing children to use alcohol, tobacco, or opium, until they are over ten years old. Opium use among the young is limited to the treatment of illnesses. Nevertheless, a small number of young men were found to be dependent, as a result of curiosity and companionship with drug users.

The Hmong are well aware of the bad effects of opium dependence. In a survey of villagers' attitudes towards opium use, about two-thirds stated that opium smoking was bad. Economic loss appeared to be the main reason. Some emphasized the beneficial therapeutic effect and considered opium smoking to be good if properly used. Opium is smoked openly in front of other members of the family, including children. Some young females who have become dependent are ashamed of their behaviour and smoke in privacy or in the woods.

MALAYSIA. Drug use in transition—fishermen traditionally used opium to alleviate the stress of a hard life but today's young people smoke heroin at the discos, perhaps to meet a new sort of stress. Dr.V. Navaratnam writes:

Whereas, traditionally, opium was smoked in opium dens or opium houses as well as during family gatherings, this is no longer true of the younger population. Drugs are used in homes, coffee houses, discotheques, recreation grounds and back-lane drink and food stalls. Dependent persons use heroin, and it is smoked in cigarette form. By tradition, opium was used for recreation or to alleviate the stress of hard work, e.g. by fishermen, who spent up to fifteen hours at a time at sea and worked up to eighteen hours a day. Nowadays, by contrast, as one study has shown, younger users begin to take drugs for various other reasons such as curiosity (about 27 per cent), peer influence (about 31 per cent), and—a surprisingly large proportion—to forget their problems (18 per cent).

Three possible explanations can be advanced for the initiation of drug use by Malaysian youth: that drug abuse provides a means of achieving subcultural acceptance; that it is a manifestation of delinquent-defiant behaviour; or that it may be a form of "self-treatment" for frustration caused by such factors as blocked opportunities and economic distress.

The third explanation is probably important in developing nations, especially those undergoing rapid industrialization. Late

Photo FAO, Johnson

adolescence and early adulthood are even in normal circumstances turbulent stages. In Malaysia, these age-groups are likely to have higher aspirations and better education than their elders. At the same time competition for education and work has increased considerably. Thus, these young people despite their better education become frustrated and look for ways of escape.

INDIA. Dr. D. Mohan writes of ebb and flow in patterns of drug use in rural Punjab and assesses the place of legal controls.

The traditionally used drugs, alcohol, opium and cannabis, seem to be still those in common use. However, there appears to be a change in the pattern of preferred drugs. Cannabis use has declined; opium use is more than the official estimates show but still seems to have declined, while alcohol use has certainly risen. Psychotropics are not widely used despite the increased health facilities. These observations are of interest, in view of the fact that legal sanctions against cannabis and opium have been in operation for a fairly long time. Though legal sanctions have con-

Below left, two members of an International Labour Organisation (ILO) vocational rehabilitation team examine an intricate piece of embroidery produced by a Thai villager. They are taking part in a vigorous campaign, launched by the Government of Thailand with the help of the United Nations, against illegal poppy cultivation and use of narcotic drugs in the mountain villages of northern Thailand. The programme, set up by the World Health Organization (WHO) and ILO, aims at treating and retraining drug addicts and at diversifying farmers' sources of income by encouraging them to grow other crops (top) and by the production of handicrafts.

Photo ILO, Geneva

In traditional societies where historically certain drugs have been used, rapid social and economic change may encourage the adoption of new habits and lifestyles accompanied by new patterns of drug use. Studies in the rural Punjab showed that one new habit formed in this context was the use of alcohol which tended to impose unfamiliar strains and tensions on the social fabric. Right, traditional and modern in Chandigarh, capital of Punjab State, India.

Photo Unesco/Arthur Gillette

trolled the availability of drugs, the decline in cannabis consumption when cannabis remained freely available is inexplicable except on social grounds. Lastly, heroin and other synthetic opiates have not appeared.

What are the implications of these observations, seen in the historical context of India's experience? The first is that there is an interplay between drugs of dependence and that, over a period of continuing availability, attitudes lead to a rise and decline in the use of particular drugs. These attitudes may be influenced by availability.

Secondly, in circumstances such as pertain to India, legal action in respect of drug-availability control should be introduced and implemented slowly. The laws should not be enforced for a considerable period of time but should remain rather as statements of intention; this is especially so when the dependence-producing substances are plant materials rather than synthetic drugs. Yet a statement of legal intention is necessary, because it tends to discourage people from becoming involved with drugs.

Drug use is closely interwoven with the socio-economic matrix of rural agrarian society. A stringent legal prohibition serves only to disrupt this tradition, and makes the appearance of substitute drugs easier. When laws are applied wisely, however, they can be a means of promoting healthy social change, by guiding the direction of change.

THE ANDEAN REGION OF SOUTH AMERICA. Coca chewing —"it is the custom". Dr. J.C. Negrete gives an account of the indigenous use of cocaine in the Peruvian uplands.

It is around 9:30 a.m. in a high valley of the Peruvian Andes. A group of peasants are taking their mid-morning break and have gathered by the side of a field. They are sorting dry coca leaves from small pouches they carry attached to their belts and gently removing the harder stems before placing the leaves one by one into one side of their mouth, between cheek and gums. The break lasts about thirty minutes. The men return to work and the renewed mouthful of coca will last them from two to three hours.

This is the second time during the day that the ritual has taken place; the first was at dawn when the men set out for the fields. It will be repeated three more times before they retire to sleep in the evening. With a few variations, this scene can be observed in thousands of farming communities throughout the central Andes, in sugar cane plantations in northern Argentina, and in the mines of the Bolivian Altiplano.

The chewing of coca leaves by men at work is the most widespread pattern of coca use. Coca use is so extensive and long-established that most chewers adopt it simply through normal socialization, with no need for a conscious individual decision, in much the same way as people learn to drink coffee elsewhere. It is no wonder that inquiries into the reasons for chewing may evoke responses such as *es costumbre* (it is the custom).

Further probing, however, reveals that coca is regarded as capable of giving Andean men "courage", "strength", "endurance", and the "will to work". Inca traditions regard industry as a virtue and despise idleness and laziness. Indeed, a common Quechua language greeting *(ama llulla, ama sua, ama qella)* includes an injunction against laziness. Many observers believe that chewing coca may help the poorer Andean people to adjust to the very limited food intake permitted by their meagre resources.

Coca also has therapeutic functions. Because of its local anaesthetic properties, it

Innocent victims

"Never before have there been so many children flirting with drugs and their associated hazards... Drug abuse is depriving today's children of the right to enter the coming century with dignity, good health, and the chance to make a substantial contribution to the future of their countries and the world." These warning words from a United Nations dossier on children and drugs draw attention to an issue which is causing concern in every world region, from the isolated hill areas where narcotics crops are grown to the urban centres of the industrialized world. Drawings on this page illustrate three aspects of a many-sided problem. (1) For some children addiction begins in the womb. The first they know of the world is the severe pain of heroin withdrawal because of their mother's habit. (2) In highly medicated societies, open, abundantly-stocked medicine cabinets may pose another problem. Combined with the example of frequent parental use, they arouse the curiosity of children and lead each year to many cases of drug abuse and fatal accidental poisoning. (3) Even more children are the victims of neglect related to parental drug abuse. In many cases, notes the UN document, "children subjected to a deficient environment inside and/or outside the home... search for escape, stimulation, relief or expanded meaning through the use of drugs."

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Photo WHO Novosti,

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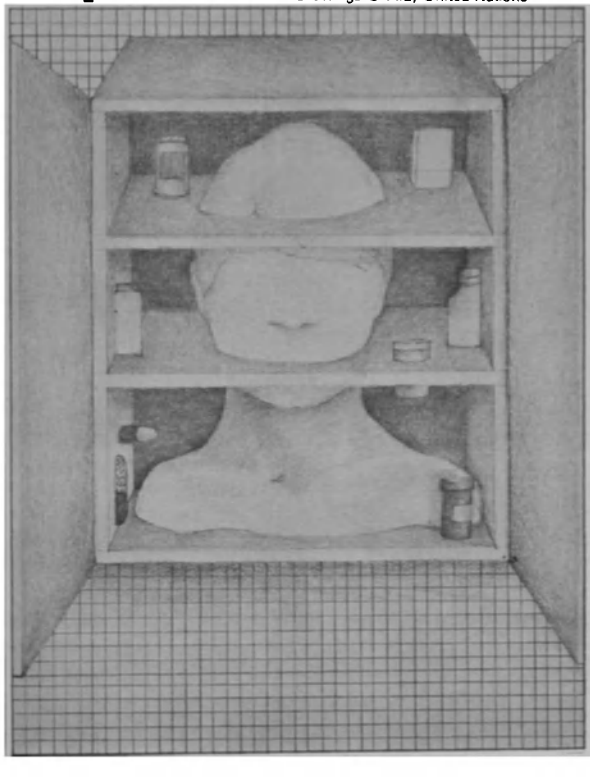

Drawings © AIE, United Nations

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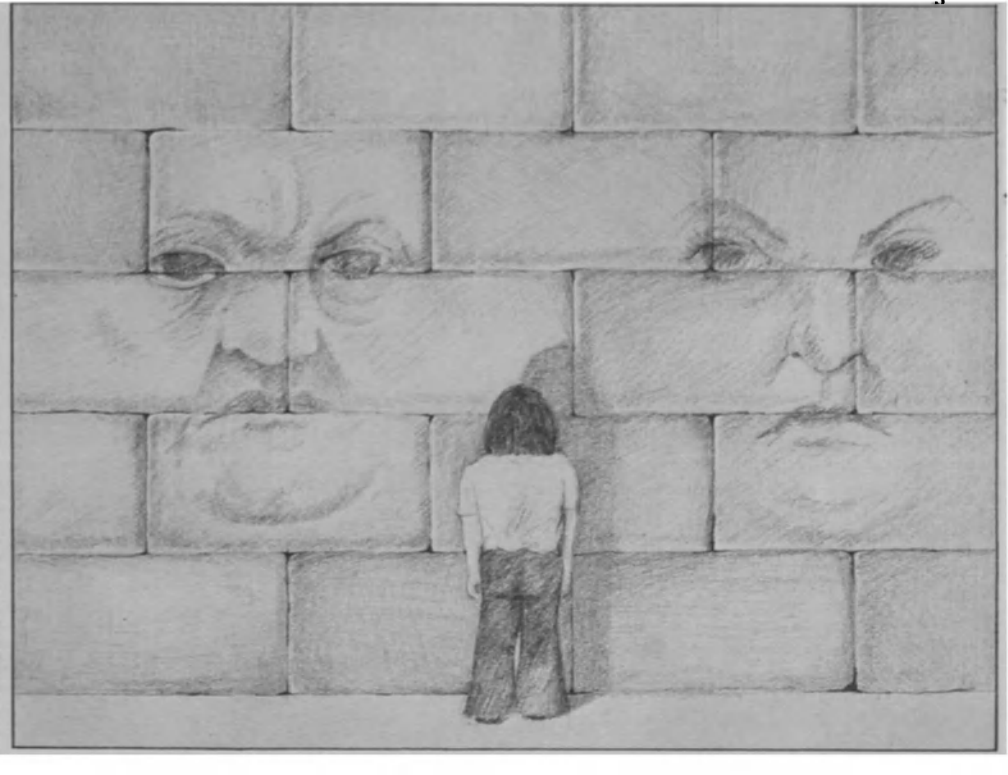

has been used traditionally with much success to treat toothache. As a hot-water infusion, it is effective against gastrointestinal disorders.

In addition to these practical functions, Andean people have traditionally attached magical properties to coca. Many workers believe it protects them from dangers such as accidents and injuries at work, and insect- and snake-bites in the fields. Another common practice is that people stick coca leaves to their forehead or cheeks in the belief that this will banish headache, worry, insomnia, toothache and other disorders.

MEXICO. Dr. R. de la Fuente gives this picture of glue-sniffing and solvent abuse among the young outcasts of Mexico City.

The children at the time of the study were under thirteen years old, the adolescents between thirteen and sixteen, and the young adults between seventeen and twenty-three. They haunted an area of Mexico City where drug-users can find places to sleep, hide, eat and take drugs; it has a market, small shops, vacant lots, cheap hotels, restaurants, tenement buildings and small squares.

The regular inhabitants are people who generally work in the area and belong mostly to the middle or lower socio-economic stratum. They have almost no contacts with the inhalers but if their paths cross the inhalers are ostracized since they are regarded as depraved. The young people, however, maintain close relations among themselves. All of them have left homes where they were used as providers for their parents, who sent them out to earn money by doing jobs like collecting garbage, selling chewing-gum or washing windows. If they came home without money they were ill-treated, so that, feeling no attachment to their families, they chose to live away.

Within a group, the adolescents use the children to obtain food and money, and seek the protection of the young adults, whose business it is to obtain and distribute the inhalant. In their search for affection the children maintain a very close relation with the other young people.

For a child to be taken into a group he undergoes a series of tests such as having his money or some of his garments taken away, or being beaten; he has to win fights and show a talent for thieving; if he passes the tests he is accepted. Upon joining he must observe certain rules of conduct or else be expelled. The main rules are not to reveal the identity of the members of the group when anyone asks, not to ask about the members' backgrounds, and to respect the freedom of others to take drugs or not as they choose.

The child inhaler then seems to develop certain characteristics. He has a practical type of intelligence, acquired through his day-to-day experiences. He is understanding and does not criticize his comrades when they cry or grieve over some recollection or deprivation. He is a rebel, rejecting every kind of authority.

UNITED STATES OF AMERICA. Chicago schools: Dr. P. Hughes describes the distribution system for many drugs, which was surprisingly overt.

Drug-using students were seen to exhibit distinctive patterns of behaviour. They were invariably found in the smoking areas during their free time, and there was generally a drug-user meeting-place outside the school but near the school grounds. They frequented certain toilets where they could stand and keep a look-out for teachers who might be supervising the area. In the lunchroom they occupied certain sections of the cafeteria where they could be contacted each day. These behaviour patterns of the drug-users were known to a significant number of students and teachers but no efforts were made to disrupt them.

One must ask, then, why do not more parents, teachers and others intervene to prevent or interfere with drug-using group activities? Some well-meaning individuals do, but all too often they have to contend with unpleasantness and even threats of violence. Friends and authorities who try to intervene usually find that talking to, or trying to help, a drug-user in the school or smoking-room, on the street corner or in the park, brings no rapid or dramatic results. Also, people familiar with the street culture may be reluctant to communicate their observations to the police or other community authorities for fear of provoking the drug users to retaliate. Nevertheless, it is likely that if enough professional workers in the field of drug abuse began to interact with drug-users in their community rather than inside the walls of their institutions new intervention strategies might evolve.

JAMAICA. Dr. M. Beaubrun describes the very different meanings and consequences of cannabis use in traditional working-class and Westernized middle-class subcultures.

Ganja, which is the local name for cannabis, has been used in Jamaica for more than one hundred years. It is readily grown, and its use, though illegal, is widespread among the lower socio-economic classes, especially the rural agricultural workers. An anthropological field study in 1970-1972 estimated that at least 60 per cent of adult males were smokers in a typical rural community. The heaviest users are a religio-political group known as Rastafarians, who ascribe divine powers to "the herb".

The Jamaican worker uses ganja as a tonic and as a nostrum for all illnesses. He uses it also to give him energy for arduous work and to relax after work. He gives it to his children to make them brighter at school and to sharpen their understanding. He attributes mystical powers to it, such as warding off evil spirits. It has been suggested that this complex of beliefs, attitudes and customs has been diffused to the Afro-Jamaican peasants, who are now the heaviest users of ganja.

There is a wide gap between these attitudes and those of middle-class Jamaicans. Ganja smoking is frowned upon by most middle-class adults. Middle-class adolescent use, though a growing phenomenon, is still largely a defiant act of rebellion coupled with an imitation of the North American culture. The middle-class adolescent uses it for curiosity, for enhancing sexual pleasure, for listening to music, for psychedelic effects and as a new experience. He has no clear rules to follow and no respectable models to imitate.

By contrast, the growing child in working-class Jamaica is gradually socialized into the use of ganja and has many role models. It may be fed to him as ganja tea even in his infant bottle. He may begin smoking at the age of seven or eight but is usually initiated in his early teens by one of his peers or in a group-smoking experience with many of the features of a *rite de passage*.

His response to the initial smoking experience seems to validate his role as a smoker or non-smoker in the ganja subculture. An initial unpleasant experience may result in his avoiding ganja thereafter and his behaviour will have cultural support. Anthropological studies indicate that the culture has developed built-in controls to minimize the ill-effects of the drug. Most important of all is learning to "titrate" so as to achieve just the result needed and no more. These built-in protective mechanisms may account for the relatively harmless picture that emerges of chronic marijuana use among working-class Jamaicans.

In contrast with this picture of cannabis use among the working class are the reports of a higher proportion of problems among middle-class youths, even though the number of users is much lower. School drop-outs, transient psychotic episodes, panic reactions and adolescent behaviour problems have all been reported.

KENYA. Dr. W. Acuda relates changes in drinking to the background of rapid socio-economic development.

There is no doubt that alcohol abuse is increasing alarmingly in Kenya. A study of alcoholism in a crowded slum area of Nairobi found that at least 46 per cent of the males and 24 per cent of the females could be classified as alcoholics. A similar study in a rural area of Kenya also found a very high prevalence of alcoholism, affecting 37 per cent of males and 34 per cent of females.

What has caused this sudden increase in alcohol consumption? There are certainly many factors involved. That most often mentioned is the rapid change that is taking place in developing countries. Kenya, like other developing countries, has undergone many changes in recent decades. In some places these changes are so rapid that the people hardly have time to adjust to them. Inevitably, this has led to stress and conflict. Given other factors, such as easy availability of alcohol, it is not surprising that there has been a sudden increase in alcohol abuse and

In many countries there are established ways of using a particular drug, which are embedded in social custom. One such drug is Khat (*Catha edulis Forsk.*), a tree that grows in East Africa, Democratic Yemen and Yemen, whose leaves and shoots have a stimulant effect. Khat is chewed in a 'colourful and scented setting' (below), often in a special room set aside for the purpose.

Photo © Pascal Maréchaux, Paris

a change in drinking patterns all over the country. Phrases like "rapid socio-economic change" are used too often and too glibly these days when talking about the developing world, without any close understanding of what this phrase really means in human terms.

Cultural traditions are disintegrating very fast in most African societies. There has been a virtual rebellion against traditional cultural values and influences. Family ties have broken down. The extended family, which sheltered so many people, has become too expensive. Extra-tribal marriages are now common, especially among the educated and these marriages are often faced with many problems.

Finally, with the spread of Christianity and the increase in knowledge, especially about medical treatment, the influence of superstition and fear of witchcraft are disappearing. People no longer believe they will be punished if they break tradition or behave immorally.

Lack of recreation or of any fulfilling use of leisure time is another cause of problems for new migrants to cities and towns. Food also can be a source of conflict.

Educated or professional people may have to adjust to a different type of problem: that of working to rigid schedules in competitive situations. In the country, life was relatively simple and unstructured, and the amount of work done depended on the individual's capacity and on natural conditions like rain, the sun and darkness.

Such changes in drinking behaviour as are taking place in Kenya, and, at a rapid pace, in many other parts of the developing world, cannot be understood without a close and sympathetic understanding of the background of cultural and social change against which they are taking place.

YEMEN. The "colourful and scented setting" of the Khat party, described by Dr. R.A. Baasher.

Khat is a tree that grows at high altitude. The leaves and young shoots provide a stimulant effect which has led to its wide use in several countries, including Democratic Yemen, Djibouti, Ethiopia, Somalia, Yemen and, to a lesser extent, in limited areas of Kenya and the United Republic of Tanzania.

Varied and complex factors underlie the use of khat. It is commonly used for social recreation and occasionally as a medicine. Because of its stimulating effects it has been used by tribal people when travelling, and in modern times by students preparing for examinations, and drivers of motor vehicles on long-distance journeys. Though nowadays khat is chewed, historically it was referred to as Arabian or Ethiopian tea, a name that denoted its use as an infusion.

As khat is chewed in a group setting, many houses in Yemen have a special room

for the purpose. It is well furnished with the best carpets, and is given a special name, such as "peace room", or "mercy room". In the centre of the room, ornamented *mada'a* (hubble bubbles) are specially placed, ready for smoking. In this colourful and scented setting members of the party arrive, everyone bringing his share of khat. On entering the carpeted room, each one takes off his shoes and sits on the mattress, leaning on the pillows. In a friendly, relaxed and joyful atmosphere the chewer plucks the leaves from the twig and meticulously chews them. Meanwhile, cold water, cola drinks or sweet menthol drinks are sipped and tea is served. The segregation of the sexes in khat parties is faithfully observed, female parties being less frequent and not so formal. Shortly after the beginning of the session, a sense of well-being dominates the atmosphere. The mind becomes very active, and the stream of talk flows easily and passionately. After about three hours the group reaches a stage when a sense of "wisdom" and self-content generally prevails. This, however, does not continue long, and in about another hour the mood changes and personal problems and difficulties emerge. Some men then become restless and irritable and they may erratically and impulsively leave the party. Those who stay behind tend to become more intimate. The discussions may continue or be adjourned, to be resumed at the next party. ■

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The role of the World Health Organization

The World Health Organization (WHO) carries wide responsibilities for the support of Member States who request aid or advice in dealing with their drug-related health problems (including problems related to alcohol and tobacco use). One of the most important functions of WHO, which falls within its co-ordinating role, is the international transfer of information on health matters, the Organization being used as a neutral ground for abstracting, assessing and disseminating information. It is a responsibility of WHO to make such information available to those who need it.

Among its priorities the Organization must co-operate with countries in relation to drug dependence in order to:

a) increase the effectiveness of health and social service delivery systems by developing effective low-cost approaches to treatment and rehabilitation of drug-dependent patients;

b) develop strategies for treatment and prevention through primary health care and in the framework of country health programmes, in countries with inadequate or no health or social care systems;

c) co-ordinate international research in drug dependence;

d) strengthen the planning of effective prevention and control programmes through the international collection and exchange of data on the epidemiology of drug dependence;

e) ensure that suitable training programmes are provided to meet manpower needs;

f) work in partnership with other United Nations agencies and organizations that have direct responsibilities for drug problems;

g) fulfil the responsibilities identified in the international conventions concerning drugs;

h) establish an effective co-ordinating mechanism whereby the knowledge and experience of non-governmental organizations and centres of excellence may be transmitted and adapted to countries with few technical and human resources.

WHO responsibilities derive from the World Health Assembly, the Executive Board and the Regional Committees, and from the International Narcotics Treaties. Resolutions adopted by the Health Assembly provide policy and priority directives to implement activities for the control of alcohol and drug problems.

During the past five years, WHO has set up a collaborative relationship with a number of centres of excellence. In the mental health programme, which includes drug dependence activities, collaborating centres serve as a link between WHO and national authorities for programme purposes; they are responsible for formal and informal exchange of information at national, regional and global levels, and they function as focal points for specific research activities, and as training centres.

So far, five centres have been designated WHO Collaborating Centres for Research and Training in Drug Dependence: the Addiction Research Foundation, Toronto, Canada; the Mexican Centre of Studies on Pharmacodependency, Mexico City; the National Institute on Drug Abuse, Rockville, Maryland, USA; the Drug Dependence Research Project, University of Sains, Penang, Malaysia; and the Health Research Institute, Chulalongkorn University, Bangkok, Thailand. ■

Lifelines

'Treatment is a cultural process and a social act'

Treatment of the individual with a drug problem must be congruent with the ways of feeling, thinking and acting normally proposed by the society and culture from which that individual derives. Treatment and rehabilitation must aim to restore the drug user to functioning as a social being within that natural environment. Treatment itself is a cultural process and a social act, and will only succeed if it is sensitively in tune with all that surrounds it.

Photo Sarah Webb Barrell © Len Sirman Press, Geneva

THAILAND. A vow to the Buddha: Dr. V. Poshyachinda gives an account of the treatment of narcotic addicts at the Tam Kraborg temple.

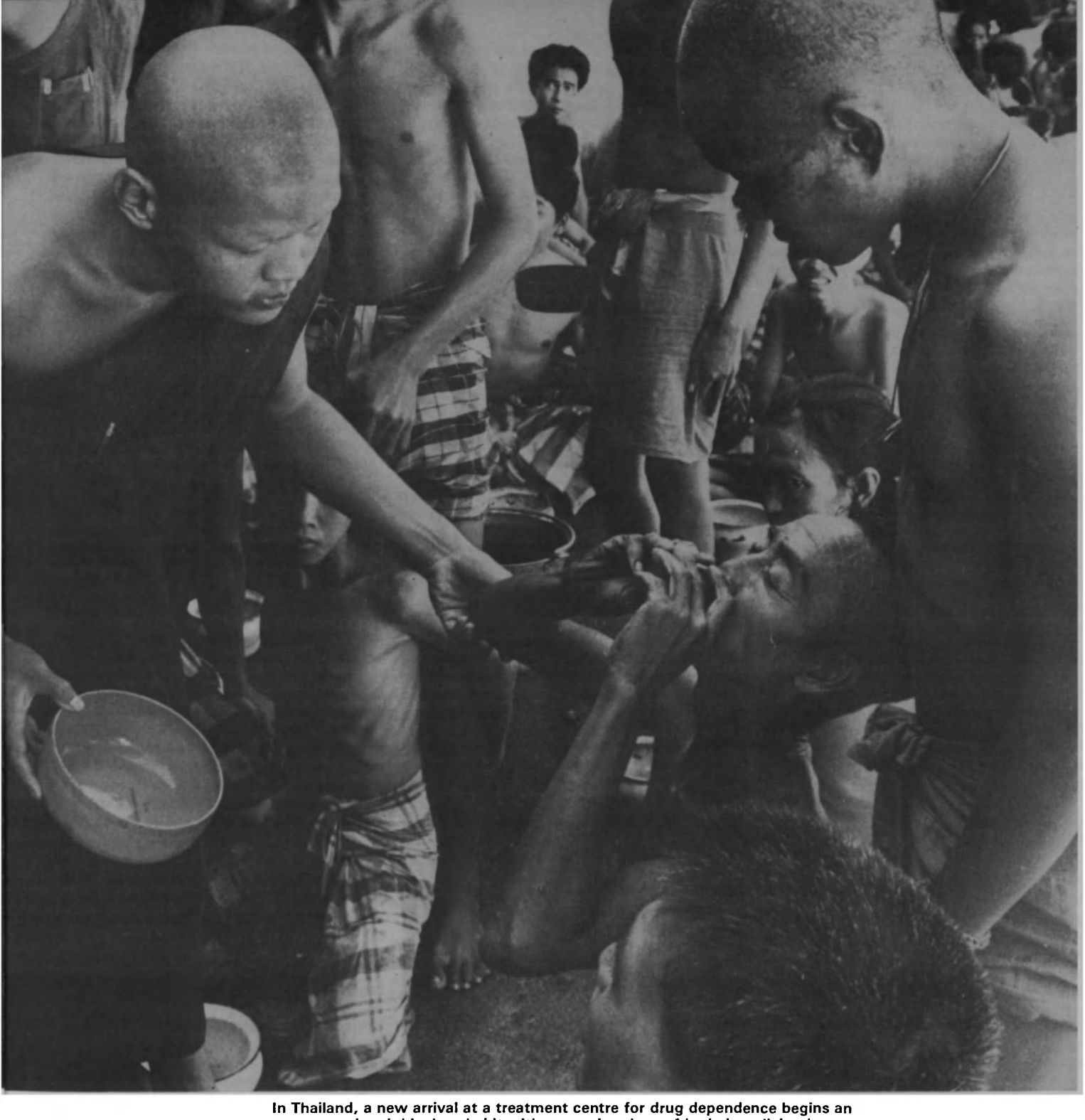
Since Thailand became a united free country over 700 years ago, Buddhism has been the national religion. The temple and the priest stand as dominating influences in society, serving many public welfare functions such as education and health care. It has been a natural evolution for the Buddhist temple to assume the role of treatment centre in response to the growth of drug dependence.

The Tam Kraborg temple is about 130 km north of Bangkok. It provides simple treatment facilities. A few wooden benches and tables placed on an open verandah serve as the intake registration unit. The living quarters for the clients are a single spacious hall not unlike a military barracks. A low wooden couch, a reed mattress and a blanket are provided for each client. When full, the temple holds 300-400 resident clients and about 100 priests. About forty of the priests are former clients who were ordained after treatment.

Treatment is carried out by a priest. The temple never has to resort to hired staff. While the treatment is free, the charge for subsistence is about US 1 dollar per day. In the last few years, the temple has developed additional supportive services for vocational training, including cultivation of crops, masonry and tailoring of ready-to-wear clothes.

The goal is complete drug abstinence for life. To enter the programme, the client must make a clear statement of determination to seek treatment. Then the client makes his vow to the Buddha. The vow is in essence a pledge of abstinence for life from opium, morphine, heroin, ganja and other drugs that cause dependence.

The daily treatment schedule for the first five days comprises two principal sessions which the clients attend in groups. A dose of herbal medicine is given in the morning, which induces immediate vomiting for about 10-15 minutes. In the afternoon session the clients take a herbal steam bath for 10-15 minutes. This cycle of sessions is explained to the client as the means whereby drugs can be purged from the body. In the morning session, clients who have already participated in the first five days join actively in the treatment. Some assist by nursing others through the vomiting session, while others cheer their fellows with spirited native tunes and jokes. The atmosphere is



In Thailand, a new arrival at a treatment centre for drug dependence begins an attempt to break his drug habit with a morning dose of herbal medicine (see story below)

not unlike that of a lively competitive game at a temple festival.

For the remaining five days, there is no prescribed schedule. The client is left to recover from his physical exhaustion. The priest usually encourages those who feel physically strong enough and are so inclined to help in the daily chores or assist in the treatment session for newcomers.

On the tenth and last days of admission, the clients are assembled again in the shrine and reminded of their pledge; they are then free to leave the temple.

HONG KONG. Houses called "Humanity", "Righteousness", "Fortitude" and "Wisdom": Dr. J. Chi'en describes the therapeutic community facility in a comprehensive community-based rehabilitation scheme for narcotic addicts which is much in tune with traditional Chinese values. This rehabilitation network was set up by the Society for the Aid and Rehabilitation of Drug Addicts (SARDA).

In 1946 the long-standing monopoly system and the legalized sale of opium were abolished in Hong Kong. In the late 1940s and early 1950s large numbers of refugees came from China to escape from the civil war; many of them were opium smokers who switched to heroin abuse after arrival.

Therapeutic communities are organized, for those who are motivated, for fuller rehabilitation after detoxification. A full course of rehabilitation runs from twenty to twenty-five weeks. A detoxified patient is invited to join any one of eighteen houses, each of which is a group-living, working and recreational unit, with its own dormitory, tea house, workshop and vegetable garden or animal farm.

The new resident earns his acceptance by the house-group through helpfulness in the dormitory and diligence in work, while the senior residents give him encouragement and advice. Confrontation techniques and attack therapy, as practised in North American therapeutic communities, are seldom applied because traditional Chinese culture advocates harmony and co-operation.

Each house bears the title of a cultural value such as "Humanity", "Righteous-

ness", "Fortitude" and "Wisdom". Leaders, who are mostly people who have gone through the programme and successfully completed the after-care period, are trained to serve as group leaders and trade instructors under the supervision of senior professional staff. Inter-group competition in cleanliness, work production, arts, and sports is encouraged and fair play as well as honesty are promoted. There is a weekly "graduation" ceremony and entertainment programme to bid farewell to those completing the full course of rehabilitation.

After leaving the centre the newly discharged are welcomed by their respective after-care workers at the head office of the Alumni Association (AA) of SARDA, which is a self-help and mutual support organization composed of and managed by ex-addicts. There are five such chapters for men and one for women, each with 200 to 300 members. Those who can maintain drug-free and crime-free living for six months are accepted by the respective chapter as associate members, and those who lead a productive life for two years in the community qualify for full membership. Badges bearing the insignia of AA in different colours to signify different numbers of years of continued abstinence from narcotics, are worn proudly by its members.

JAPAN. Dr. H. Suwaki describes the organization and working of Danshukai, the Alcohol Abstinence Society. Wives and children can become members.

There are some noticeable differences in the treatment of alcoholism between Japan and the West. Alcoholics Anonymous (AA), which is popular in the West, is found in only limited areas of Japan such as Yokohama and Kobe where Westerners live together. Instead of AA, Danshukai (Alcohol Abstinence Society) is widespread throughout Japan. A very active Danshukai was organized in Kochi Prefecture in 1958. The founder had himself been admitted to a mental hospital five times for alcoholism.

By 1977 one was established in every prefecture in Japan, with 586 chapters and 35,000 registered alcoholic members. Twenty-five thousand members were attending the meetings in 1977, and 16,000 had abstained from alcohol over one year.

The activities of the Danshukai are family and experience oriented and rooted in the local community. Regular meetings of the headquarters, chapters and hospital groups are held from one to four times a month. Usually one of the experienced members takes the chair. Psychiatrists, social workers and psychologists co-operate with the Danshukai and often attend meetings. A small meeting, called a block meeting, is held at the homes of members who live near each other and want to come together. In addition to the meetings, the members participate in various recreational activities to develop closer relations among the members and their families. They also join the other Danshukai and Alcohol Abstinence schools in neighbouring prefectures, and read the Danshukai bulletin.

The Danshukai has affirmed the following three principles as its basic policy, in the light of the experience accumulated so far:

a) There is no alternative but for alcoholics to abstain from drinking, since they cannot drink moderately.

b) An alcoholic cannot cure the disease by himself. The way to a successful cure is

Photos © SARDA, Hong Kong

Below, members of the Alumni Association of Hong Kong's Society for the Aid and Rehabilitation of Addicts (SARDA) gather to take part in their "Walk for a Million". This annual event raises funds for the Community Chest for Hong Kong which provides many voluntary welfare agencies with financial support. Above, "drug-free badges" are awarded at the Association's annual assembly.

open only when those who have suffered alcoholism encourage each other at a Danshukai meeting.

c) Co-operation of the family, particularly of wives, is indispensable for alcoholics to continue abstaining.

The wives and children of Danshukai members usually belong to the same Danshukai as their husbands or fathers, although some Danshukai have developed wives' groups as an extended activity.

Almost all the members are male alcoholics. There are not more than twenty female alcoholics in the Danshukai throughout Japan. Danshukai is not anonymous. Many Danshukai publish the addresses of the members, and outside persons can join the meeting and talk freely in the group.

The treatment of alcoholism will not serve its purpose well if it deals merely with physical and psychological needs. It must contain elements of an individual's beliefs, which largely have their roots in his cultural traditions.

Photo © Hiroshi Suwaki, Kochi, Japan

Male alcoholics and their wives attend a weekly meeting of a branch of *Danshukai,* Japan's Alcohol Abstinence Society.

ALCOHOLICS ANONYMOUS. Dr. D. Robinson analyses the cultural origins and international diffusion of AA, a self-help group which has shown an extraordinary ability to reach the needs of the alcoholic. What have the professionals to learn?

Of all self-help groups Alcoholics Anonymous (AA) has perhaps the most well developed written history. AA originated in the chance meeting at Akron, Ohio, in the summer of 1935 between Robert Holbrook Smith, a local doctor, and William Wilson, a New York stockbroker. A year earlier, Wilson had been introduced to the Oxford Group Movement by a friend who said he was staying sober by attending their small discussion-group meetings and following their precepts: confession, honesty, talking out of emotional problems, unselfishness, making reparations and praying to God as personally conceived.

Impressed by his friend's efforts, Wilson attended some meetings and after a spiritual awakening found that he also could remain sober. However, he failed to convert other alcoholics because of what his doctor called "too much preaching". So he decided to try to convince them that they had some kind of physical allergy and mental obsession and only to introduce the spiritual aspects later. This worked first with "Dr. Bob".

Alcoholics Anonymous did not invent the idea of addiction, or loss of control, any more than they invented total abstinence as the only goal of treatment. Nevertheless they played a major part in the development of the new disease conception of alcoholism in the post-Prohibition period.

Alcoholics Anonymous would not have developed as rapidly as it has done if it had not been based on ideas that were compatible with dominant ideas in the American culture. The USA in the nineteenth century was above all a middle-class nation in which an open capitalist society required individuals to regulate their business, family and personal activities in order to survive and succeed.

At that time, in both Europe and North America, madness was increasingly being defined as a disease, the chief symptom of which was loss of control. The asylum was changing from being a place of chains and physical control to becoming a place to restore, through moral treatment, the power of self-discipline to those who had lost it. It became natural, therefore, to redefine almost all evil or deviance, including alcohol problems, as disease of will. And, because self-reliance had become such an essential feature of belief and culture, in the USA anything that undermined self-reliance or self-control became a matter of great importance. Liquor was regarded as important since it would weaken inhibitions in the short run and deprive people of the ability to live restrained, moderate and controlled lives. In AA terms, it could make their lives 'unmanageable".

Just as AA's ideas about the nature of the problem had to be compatible with dominant ideas, thought and culture in the USA, so did the principles underpinning its programme of action. At a personal level the programme aims at transforming the dependent, isolated, drinking alcoholic into an independent, integrated, sober alcoholic. At a group level AA aims at being a self-reliant, self-sufficient organization, beholden to no one and dependent on no one. It remains uninvolved in outside philosophical, political, social or spiritual issues although it co-operates with other bodies in order to help to bring as many alcoholics to sobriety as it can and help them to "conform to the norms of a dominant middle-class society".

It is not surprising therefore that AA should be so well regarded in North America. However, the fellowship has now grown from its meagre beginnings, in Akron in 1935, into a worldwide organization of groups. By 1974, the General Service Board of AA was claiming that world membership had reached 800,000 and by 1977 well over 1,000,000. There are groups now in over 100 different countries from Norway to Nicaragua and from Trinidad to Thailand.

On a worldwide scale Alcoholics Anonymous has groups in Catholic and Protestant countries, in developed and developing countries, in beer-producing and wine-producing countries, in countries with private medical care and those with State health care systems. But although AA is widespread, its development has, naturally, been uneven. It is also thin in Eastern Europe although there are the well-known clubs in Yugoslavia and elsewhere which operate on somewhat similar lines to A.A. In the Middle East and India very many of the members are employees of foreign firms, while in Asia many of the groups were started by the US forces. But in all areas of the world the number of groups is growing.

Two major themes run through most of the accounts of why self-help health groups are flourishing today. The first is the disillusionment with existing helping services: the feeling that expectations have not been fulfilled or that services are unable to provide the kind of care that is needed. The second is the recognition that in many societies the traditional support systems such as the church, the neighbourhood and the extended family are in decline. As a result there is a search for community by people who feel helpless and without control over their own lives. For many, the world has moved too fast, is too big and is too indifferent to quality, to individual differences and to the basic human needs of understanding, friendship and support.

Alcoholics Anonymous has never been made the subject of an international study.

It is not possible, therefore, to say how the fellowship has adapted to varying socio-cultural circumstances. But given the well-known variation between groups within the same city it is reasonable to assume that AA in Thailand is somewhat different from AA in Nicaragua. This is one of the strengths of the fellowship: its ability to adapt to the needs of its members, provided always that it keeps faith with the surprisingly few core principles and practices which are the essence of AA.

There is no doubt that Alcoholics Anonymous, with its basis of mutual concern and continuing support together with its record of, and public commitment to, co-operation with others working in the field, could have a part to play in an overall response to alcohol-related problems in any country.

UNITED KINGDOM. Dr. R. Wille examines the "natural processes" which interacted with the drug maintenance treatment given by a clinic to bring about the eventual recovery of one young heroin addict.

Treatment is only one variable in a very complex field of forces. We need to consider how people do things for themselves, how they use friends and families, how their lives interact with chance and life events, and then see treatment in this context insofar as it adds to those natural processes.

Bob O. started using heroin at the age of sixteen. He had four criminal convictions between the ages of eleven and seventeen. His first clinic attendance was at the age of eighteen in June 1968. His first prescription was for 120 mg heroin. By 1969 his prescription had become reduced to 30 mg heroin and 30 mg methadone. During this period (1969) his life was becoming more and more chaotic. He started to inject sleeping pills, lost his job, and was found unconscious on the road by the police with an accidental overdose of barbiturates. He comments on the first reduction in 1969: "It was a period when I wasn't ready to come down. And if the doctors force you down then, it's just a waste of time".

At the beginning of 1970 his prescription was increased to 70 mg heroin and 40 mg methadone, a dose on which he was kept until 1972. At this time a gradual stabilization of his drug use and social situation began. He was worried by his physical deterioration, his abscesses and overdoses, the death of his best friend from a barbiturate overdose, the decline of his old drug scene, and his mother's illness and her complaints about his way of life. He ceased taking sleeping pills and started working regularly. He stopped his contact with the drug scene and became, as he expressed it, a "loner". He undertook a slow reduction of drugs over the next two years and regarded this as the best possible way for him to become abstinent.

Why was this second reduction successful? Bob O. reported that he made the decision because he met his new girl-friend who did not want to marry him as long as he was addicted. After ten years of heroin use he became abstinent at the age of twenty-six, married his girl-friend and, a short time afterwards, completed a course as a carpenter and started a successful career. He has his own house and car, and has been abstinent now for four years.

For Bob O., the development of a new social role—manifested by a stable job and a significant relationship—interacted with chance and life events. Therapeutic efforts were successful when they complemented these social changes. ■

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Alcohol consumption in 25 countries per capita (15 years and older) in litres of 100 per cent ethanol.

Country*	Consumption 1976	Average annual percentage change 1970-1976
France	21.3	− 2
Portugal	19.4	+ 4
Spain	19.3	+ 2
Luxembourg	16.8	+ 0.6
Italy	16.8	− 3
Fed. Rep. of Germany	15.8	− 0.2
Austria	14.6	+ 2
New Zealand	13.7	+ 4
Hungary	13.4	+ 0.6
Australia	13.3	+ 1
Switzerland	13.2	− 2
Belgium	13.2	0
Ireland	12.6	+12
Yugoslavia	12.0	+ 3
Czechoslovakia	11.9	− 3
Denmark	11.8	+ 4
Canada	11.7	+ 4
Netherlands	11.1	+ 7
United Kingdom	11.0	+ 5
Poland	10.8	+ 7
USA	10.7	+ 2
German Dem. Rep.	10.5	0
Finland	8.1	+ 5
Sweden	7.4	− 1
Norway	5.6	+ 5

*Classed by order of consumption.
Sources: International Labour Organisation (1977); United Nations (1977). Produktschap voor Gedistilleerde Dranken (1977).

An ABC of drugs

Natural and synthetic substances under international control

The opium poppy (*Papaver somniferum* L.)

This article has been extracted from a booklet The United Nations and Drug Abuse Control *produced by the UN Division of Narcotic Drugs, Geneva (United Nations, New York, 1977).*

Natural and synthetic opiates

Opium. Opium is the coagulated juice from the unripe capsule of the poppy plant scientifically known as *Papaver somniferum*. It can be grown in most areas of the world, and in a number of countries it is cultivated for its seeds or beautiful flowers rather than for its opium content. The seeds, which constitute a valuable oil-containing food, are pressed for oil or used in cakes and pastry. The poppy is an annual plant and most probably originated in the Mediterranean region and in the Middle East.

The earliest recorded knowledge of opium is to be found in the Sumerian tablets. Sumerians lived in Lower Mesopotamia (modern Iraq) around 5000 BC. Later, knowledge of the poppy's medicinal properties was introduced to Persia and Egypt by the Babylonians. The Greeks and Arabs also used opium for medicinal purposes. The first recorded instance of poppy cultivation in India dates from the eleventh century, and production and consumption of opium in that country became extensive in the sixteenth century during Mongol rule.

Opium was probably introduced to China by the Arabs in the ninth or tenth century. The drug was also known in Europe in the Middle Ages, and the famous physician Paracelsus administered it to his patients.

Opium was medically a very important drug, but the prominent place it held in therapy has been taken over by certain of its alkaloid (morphine and codeine), and synthetic opiates (pethidine and methadone). Formerly a useful therapeutic agent, opium has now become an important raw material for the manufacture of morphine and codeine.

As a pleasure-giving drug, opium was originally eaten or taken as an infusion. The smoking of opium is a comparatively recent development, going back only a few hundred years.

The abuse of opium and its derivates (morphine and heroin) was the primary concern of the first international attempts to enforce control of narcotic drugs.

Morphine. Morphine is the main active principle of opium. The average morphine content of opium is about 10 per cent. Morphine is extracted either from opium or, directly, from the poppy straw (the dried capsules and the upper part of the stems of the opium poppy after mowing). The use of the poppy straw process eliminates the production of opium and greatly reduces all risks of abuse and illicit traffic. This process has expanded greatly and, in recent years, about one third of the world's medical requirements for morphine has been manufactured from poppy straw.

Morphine was widely used for the relief of short-term acute pain resulting from surgery, fractures and burns and in the final stages of terminal illnesses. Through the introduction of synthetic narcotics and other analgesic drugs, the extent of use and the therapeutic importance of morphine have been considerably diminished (but it is still considered to be the prototype of the narcotic drug).

Codeine and other morphine derivatives. Codeine, an effective cough suppressant, is one of the most commonly and widely employed medicaments. Codeine (methylmorphine) occurs in opium in low concentration, but for the market is manufactured principally by the conversion of morphine. This explains the apparent contradiction between the decrease in the therapeutic use of morphine and the increase in its production: more than 90 per cent of the morphine produced by the pharmaceutical industry is converted into codeine. It has properties which resemble those of morphine but its analgesic effects are milder.

Cases of codeine addiction are relatively rare, as dependence develops only after continued consumption of large quantities over a considerable period of time.

Heroin. Heroin (diacetylmorphine) is derived from morphine by acetylation. On the recommendation of the World Health Organization and the Commission on Narcotic Drugs, it has been banned in most countries, and its use in medicine has been replaced by other, less dangerous analgesics.

Heroin is perhaps the most addictive of all known drugs. The intense euphoria produced by the drug has made heroin the most popular morphine derivative among addicts.

The quality of the drug available on the black market relates to several illicit activities, and during the long process from the clandestine laboratory to the smuggler and from the smuggler to the street addict, the original heroin is diluted so many times that the white (or pink or brown) stuff in a "bag" may not contain more than 3 to 5 per cent heroin, in some countries. Adulteration of heroin is the easiest way for traffickers to increase their profit.

Synthetic opiates. The term "synthetic opiates" or "synthetic narcotics" is generally applied to a number of addictive substances which have come onto the market since the discovery of pethidine by German chemists some thirty years ago. When first marketed, pethidine was claimed to be devoid of addictive potential; experience, however, has proved otherwise. Addiction is slower to develop and is less vicious than addiction to morphine, but this potential does exist.

The mushrooming development of various new synthetic drugs and their appearance on the market, accompanied sometimes by unproven claims that they do not produce drug dependence, have led the Commission on Narcotic Drugs to repeat warnings to Governments to apply immediately provisional control measures to these substances, pending the definite evaluation of their effects by the World Health Organization. The Commission has taken the view that in such cases commercial interests must yield to overriding considerations of public health. In this connexion, it has also been stressed that, without encroaching upon the freedom of the press, a way should be sought to prohibit misleading publicity and advertising of properties of newly developed drugs.

A plant of the genus cannabis

Cannabis

The products of the plant *Cannabis sativa L.* have been used by millions of people as an intoxicant over the last four or five thousand years. It is used in various forms. People smoke it, often combined with tobacco, or mix its resin with drinks or in sweetmeats. Such use is still tolerated in some countries.

There are few areas in the world where cannabis cannot be grown successfully. Depending on the soil, the climatic conditions and the degree of cultivation, this weed-like plant may reach a height of from one to twenty feet. The cannabis plant or the crude drug derived from it and folk preparations of cannabis are known under hundreds of different names. The intoxicating constituents of the cannabis resin (known as hashish) are found mainly in the flowering tops, particularly of the female plant. Cannabis resin was the most potent form of cannabis, until recent years, when a new cannabis product appeared on the illicit market: liquid cannabis is a concentrate containing sometimes up to 60 per cent of THC (tetrahydrocannabinol) and is more dangerous than other forms of cannabis.

There are indications that the intoxicating effects of cannabis depend largely on the amount of THC present in the "cannabis" used.

According to the Single Convention, 1961, the term "cannabis" means, *"the flowering or fruiting tops of the cannabis plant (excluding the seeds and leaves when not accompanied by the tops) from which the resin has not been extracted, by whatever name they may be designated"* but in common parlance the use of the term "cannabis" can differ from this definition, and the expressions "cannabis", "marijuana" or "hashish" embrace a range of different cannabis preparations.

Cannabis has become, from the medical point of view, an obsolete remedy. It has therefore been recommended that its use be discontinued in medical practice, but it is still used for the treatment of certain ailments by local medical practitioners in some countries in Asia.

In certain countries, the consumption of cannabis has been a traditional custom for centuries, particularly in regions where the consumption of alcohol is prohibited.

From Unesco... Further information on drugs

Drugs Demystified, by Helen Nowlis. This pamphlet published by the Unesco Press is available in English, Arabic, French German, Italian, Portuguese, Spanish, Swedish and Thai.

The Aetiology of Psychoactive Substance Use. A report and critically annotated bibliography on research into the aetiology of alcohol, nicotine, opiate and other psychoactive substance use, by C. Fazey. Carried out with

A coca bush (*Erythroxylon* coca)

LSD

Coca leaf and cocaine

The coca bush is an evergreen shrub *Erythroxylon coca* which grows in western South America. The leaves have been chewed for centuries in some parts of South America by highland peoples. The leaves are also the raw material for the manufacture of cocaine.

Since the habit of coca-leaf chewing is conditioned by a number of unfavourable social and economic factors, the solution of the problem involves two fundamental and parallel aspects; the need for improving the living conditions of the population among which coca-leaf chewing is a general habit and the need for initiating simultaneously a governmental policy to limit the cultivation of the coca leaf, control its distribution and eradicate the practice of chewing. The U.N. Economic and Social Council has recommended that the countries affected by the coca-leaf chewing habit be assisted in their efforts to eradicate this practice.

Cocaine, a potent stimulant* drug, is the principal alkaloid of the coca leaf and can be extracted from coca leaves. It was first used as a local anaesthetic a century ago, but its therapeutic importance has diminished with the introduction of other anaesthetic drugs. In the case of abuse, the stimulant effect of cocaine results in excitability, talkativeness and a diminished feeling of fatigue. Cocaine may produce euphoria and the sensation of increased muscular strength. Stimulation is followed by a period of depression. High doses of cocaine lead to suspiciousness, fear, hallucinations (characteristics of a paranoid psychosis) and aggressive and antisocial behaviour may occur. Effects of cocaine are similar to the effects produced by amphetamines.

*** Pharmacologically speaking cocaine is a stimulant of the central nervous system, legally it is controlled by the Single Convention on Narcotic Drugs. Adopted in 1961, the United Nations Single Convention on Narcotics came into force in 1964. It replaced nine existing treaties on international narcotics control, extended control to the cultivation of plants from which "natural" narcotic drugs (opium, cannabis, coca leaves) are obtained, and simplified the international control machinery. It was amended in 1972 with the aim of further strengthening the international drug control system.**

Hallucinogens

The great civilizations offer numerous examples of the use of substances producing hallucinations. The ritual consumption of hallucinogenic mushrooms in America, the use of other intoxicating mushrooms by sorcerers in Asia and the use of certain plants for witchcraft in Europe are only a few examples of the diversity of the "traditional" hallucinogens, but recently the term "hallucinogenic" has been more associated with Lysergic acid diethylamide (LSD) (STP), (DMT) and other new substances.

Hallucinogens constitute a heterogeneous class of substances, belonging to a wide variety of chemical and pharmacological groups. The propagation of their abuse and its resultant effects have led to the international control of a number of hallucinogens. The guiding principle of the Convention on Psychotropic Substances, 1971, in the selection of hallucinogenic substances to be controlled is expressed in Article 2 of that Convention. A substance should be subject to control "if the World Health Organization finds: that the substance has the capacity to produce... central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behaviour or perception or mood... and that there is sufficient evidence that the substance is being or is likely to be abused so as to constitute a public health and social problem."

LSD. Lsd (LSD-25, lysergide) is an abbreviation of the German expression for lysergic acid diethylamide *Lysergsäure Diäthylamid).* LSD is a synthetic or, more precisely, a semi-synthetic compound, since it is not found as such in any natural material, but is produced from lysergic acid, a natural substance found in ergot of rye.

For a "psychedelic trip", 100-250 microgrammes (1 microgramme = 0,000001 Gm) of LSD are used in the form of a diluted solution or mixed with other substances in capsule form. Drops of the solution are usually taken on a lump of sugar or on blotting paper.

the financial support of the United Nations Fund for Drug Abuse Control (UNFDAC), 1977. 48 French francs.

SOS Drogue, a 16 mm colour film produced in 1979 by the Ivory Coast out-of-school television education service (in French).

The Jigsaw Puzzle of Drugs. The Unesco Courier, May 1973.

Requests should be addressed to: Mme N. Friederich, Education concerning problems connected with use of drugs, Unesco, Place de Fontenoy, 75700 Paris, France.

Hallucinogenic mushrooms.

Peyote cactus.

Amphetamine-type stimulants and sedative-hypnotics.

The ingestion of LSD produces changes in mood, alteration in sense of time, distortion in visual and auditory perception, depersonalization, derealization, auditory and optical hallucinations.

The most common reactions during a trip are as follows:

Panic reaction: this appears when the "traveller" becomes aware that he cannot control the effects of LSD; he cannot beat them and tries in vain to end them.

Paranoid reaction: under the effect of LSD, he has the impression that someone wants to imprison him or "control his mind".

Mescaline. Mescaline is the active principle of the peyote cactus. The scientific name of this cactus is *Lophophora Williamsii;* its popular name, peyote, appears to be of Aztec origin. This small, fleshy, spineless cactus grows wild on the Mexican plateau and in the south-western part of the United States in dry places, on cliffs or on rocky slopes.

Peyote was used and revered as a panacea, an amulet and a hallucinogen in the mountainous regions of northern Mexico centuries before the European arrived, in the 15th century. Peyote has long been taken by the Huichol Indians, as a medicine, to induce visions leading to prophetic utterances and, collectively to obtain the desired state of trance for ritual activities. (See *Unesco Courier*, February 1979.).

Mescaline is a less potent hallucinogen than LSD, but its effects are very similar, with personality disturbances and symptoms similar to those of schizophrenia.

Psilocybine, psilocine. Psylocybine and psilocine are the active principles of the hallucinogenic mushroom *Psilocybe mexicana*. This fungus is the most important of the sacred mushrooms worshipped by the Indians of Mexico, who have long used "teonanacatl" (flesh of the gods) in Aztec religious rites.

Due to the care used by the Indians in withholding information, it was only a few years ago that some of the sacred mushrooms, including *Psilocybe*, could be identified. The pharmacological study of these compounds has confirmed the strong hallucinogenic properties of the drug.

DMT, DET. DMT and DET are abbreviations for dimethyltryptamine and diethyltryptamine, respectively. Both produce strong hallucinogenic effects. DMT is also the active principle of a number of South American snuffs, which are snuffed into the nasal cavity.

Such central substances are used by the Indians in religious ceremonies to produce mystical states of mind which are said to enable them to communicate with their gods.

Psilocine and psilocybine are chemically closely related to DMT.

STP. The letters "STP" (dimethoxymethamphetamine) designate a synthetic compound produced in "underground" laboratories. STP is chemically related to mescaline and the amphetamines; its action is of longer duration than that of LSD.

THC. THC designates tetrahydrocannabinol, one the active principles of cannabis. THC is a very potent hallucinogenic drug, with pharmacological effects showing several similarities to those of LSD; these are changes in mood, alteration in sense of time, distortion in visual and auditory perception, depersonalization, derealization, auditory and optical modifications. However, there are indications that the two drugs probably act through different biochemical mechanisms, and their effects on brain function are somewhat different.

Stimulants

The most important stimulants are the amphetamines. The term "amphetamines" includes synthetic amines which are similar in many respects to the human body's hormone adrenalin. Amphetamines, like cocaine, suppress appetite, increase activity and alertness and arouse the central nervous system. These drugs were synthesized at the beginning of the 20th century and used therapeutically in the 1930s. Because of their stimulating effects amphetamines were widely used by soldiers, particularly pilots during the Second World War. Amphetamine, dexamphetamine, methamphetamine are the most common substances of this group. Other substances such as phenmetrazine and methylphenidate have very similar pharmacological effets. Stimulants are widely used and abused by truck drivers on long trips, by students when preparing for exams, and by athletes (doping) in efforts to increase performance.

Widespread abuse of amphetamines has occurred during the last thirty years in urban areas of many countries. In some countries the abuse reached epidemic proportions which compelled the authorities to put these substances under strict control.

The therapeutic value of such medicines is rather limited, being confined, in practice, in some countries to two types of cases in which they are used: (i) as stimulants in selected conditions and (ii) for the treatment of obesity. Since these substances have a strong suppressive effect on appetite this action disappears after a few weeks as well as their stimulating effect, unless the dose is increased. In the opinion of some experts, the prescription of amphetamines is justified only for the treatment of narcolepsy (a very rare illness).

In contrast with the limited medicinal use of amphetamines, there is a large-scale illicit traffic and abuse of these drugs in certain countries.

Amphetamines, as medicine, are generally taken in the form of tablets and capsules.The most harmful form of amphetamine abuse is produced by the ad-

ministration of excessive doses of methamphetamine ("speed") intravenously. This new phenomenon of injecting stimulants may last several days and is characterized at the end of the "run" by a state of hostility, aggression and paranoia produced by the continued administration intravenously of massive doses of "speed". Heavy abusers of stimulants are not able to work regularly because of their drug dependence.

Amphetamines and other stimulants are very often abused in combination or in alternation with other drugs such as barbiturates or opiates. It is worth noting that STP (dimethoxymethamphetamine) and MDA (methylenedioxyamphetamine), two potent hallucinogens, are chemically closely related to the amphetamines.

Sedatives-hypnotics

Barbiturates. The most employed sedatives-hypnotics belong to the group of barbiturates. They have been used in medicine for over half a century, and in a number of countries they account for about 10 per cent of the medical prescriptions. Barbiturates may be considered "safe" if they are used under appropriate medical supervision as hypnotics (sleeping pills) or sedatives in small doses or in larger doses as anaesthetics. Their therapeutic usefulness is in marked contrast with that of the amphetamines which is very limited. Regular use of barbiturates produces profound physical dependence.

In a number of countries, the use of barbiturates is not subject to control. This has serious consequences, such as the danger of dependence; in addition, the uncontrolled use of barbiturates may lead to combined abuse—that is, to the use of barbiturates in conjunction with other substances. The three most widespread and dangerous associations are barbiturates when used in combination with heroin, with alcohol or with stimulants.

Minor tranquillizers. There are a large number of medicaments known as minor tranquillizers which are mainly prescribed for patients suffering from an anxiety or tension. Many of these substances are widely used and abused. In many countries, the production of, trade in and distribution of these substances are not subject to effective control (where there is any form of control) and cases of addiction to minor tranquillizers have been observed. Overdose fatalities due to minor tranquillizers have been observed but with less frequency than with the barbiturates. Minor tranquillizers (such as methaqualone, etc...) are often taken in combination with other drugs to obtain either longer lasting effects or enhance the effects of other drugs. ■

Swallowed, sniffed, injected...

Many drugs are taken just by their being swallowed. There is then a fairly long interval between taking the drug and its maximum impact on the brain, and learning theory suggests that the time-interval conditions will not be optimal for rapid establishment of addiction, although drugs taken in this manner can certainly set up an addiction. Alcohol is a prime example of a drug which is ingested; cannabis may be swallowed in cakes or as an infusion; opium may be eaten; and all manner of synthetic substances are taken in pill form. A rather more rapid way of obtaining an effect from some substances is to keep the drug in the mouth pocketed against a cheek, and hence the efficacity of tobacco or khat chewing or coca taken in this manner.

For some drugs an even more effective way of ensuring rapid absorption may be to sniff or smoke the substance—smoked tobacco, smoked opium, heroin taken by "chasing the dragon", glue and solvents which are inhaled, cocaine sniffing, smoked coca paste, and the cannabis cigarette. The highly addictive nature of cigarette smoking stems from the fact that this rolled-up tube is a brilliantly designed piece of technology for getting nicotine very rapidly to the brain—each draw on the end of that cigarette shoots another dose of nicotine into the blood stream to reach the brain within seconds.

But where technology really takes over is with the availability of the needle and the syringe, and drugs in injectable form. Heroin derived from opium and injected in this manner is going to be much more rapidly addictive than the plant product as traditionally smoked. However, the major danger of this innovation is that accidental over-dose becomes all too easy, as do the possibilities of accidentally introducing contaminants or bacteria into the blood stream. The traditional opium smoker or opium eater did not necessarily harm his health or shorten his life. On the other hand the heroin injector not only runs the risk of death by acute over-dose, but of contracting infective conditions as diverse as bacterial septicaemia, tetanus, and malaria: average life expectancy is shortened not directly because of the heroin itself, but because of the unsterile injection.

■ **Griffith Edwards**

A pill for every ill

by Ruth Cooperstock

Increasingly the world expects a pill for every ill. What is to be done about patient expectations and medical prescribing? Dr. Cooperstock focusses on benzodiazepines (the minor tranquillizer group which includes such well-known products as valium and librium).

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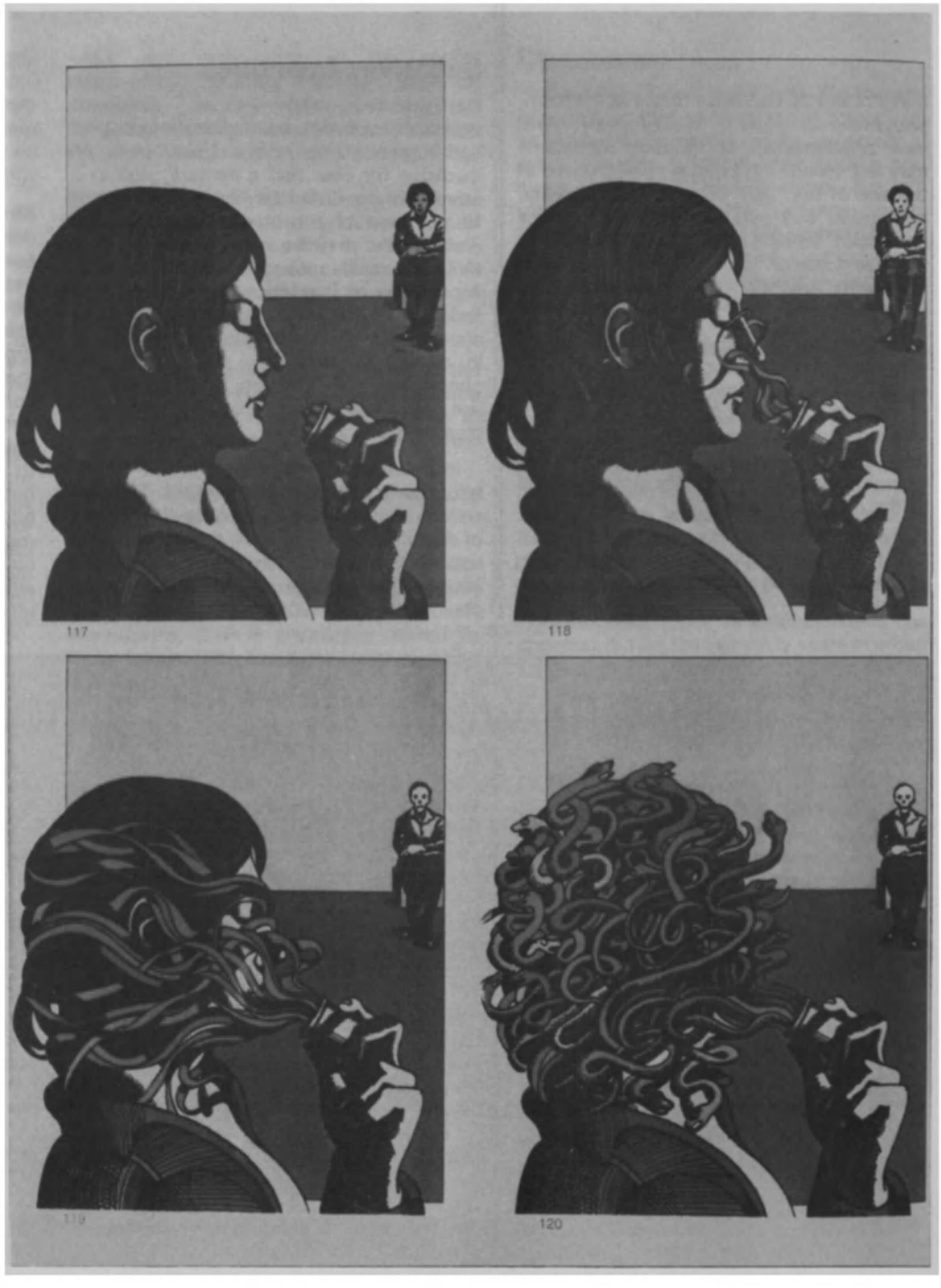


THE pharmaceutical industry is expanding worldwide at an annual rate of over 10 per cent. The benzodiazepines, introduced in the early 1960s with chlordiazepoxide (Librium) and then diazepam (Valium), were initially marketed as anti-anxiety agents. Psychiatric disorders and the emotional discomforts of everyday life were to be eliminated. Gradually, as more benzodiazepines came on to the market (and there are now scores of this class of drug) the indications for their use expanded to include not only daytime sedation, but also night-time sedation, muscle relaxation and anti-convulsant therapy. Additionally, a number of combination drugs appeared which included a benzodiazepine. These were recommended for a wide range of psychosomatic disorders. Acceptance of the benzodiazepines was remarkably quick. Within less than fifteen years diazepam was the largest-selling drug in the world.

It is increasingly clear that use of benzodiazepines is not randomly distributed in populations. Women receive twice as many prescriptions as men. The elderly and the chronically ill are the major recipients in addition to people in institutions. It is in these groups that long-term use is most likely. Because of their ready availability, these drugs, combined with alcohol, are the most commonly found in overdoses in Canada and the USA. Additional studies of motor impairment (especially likely to affect driving skills) and of impairment of intellectual functioning, judgement and social skills are now appearing. Thus, while there are clear short-term benefits from these drugs, an array of minor and major problems have been created by their use. Other problems of a more subtle nature relate to some of the social and behavioural consequences of use, and are only now being explored.

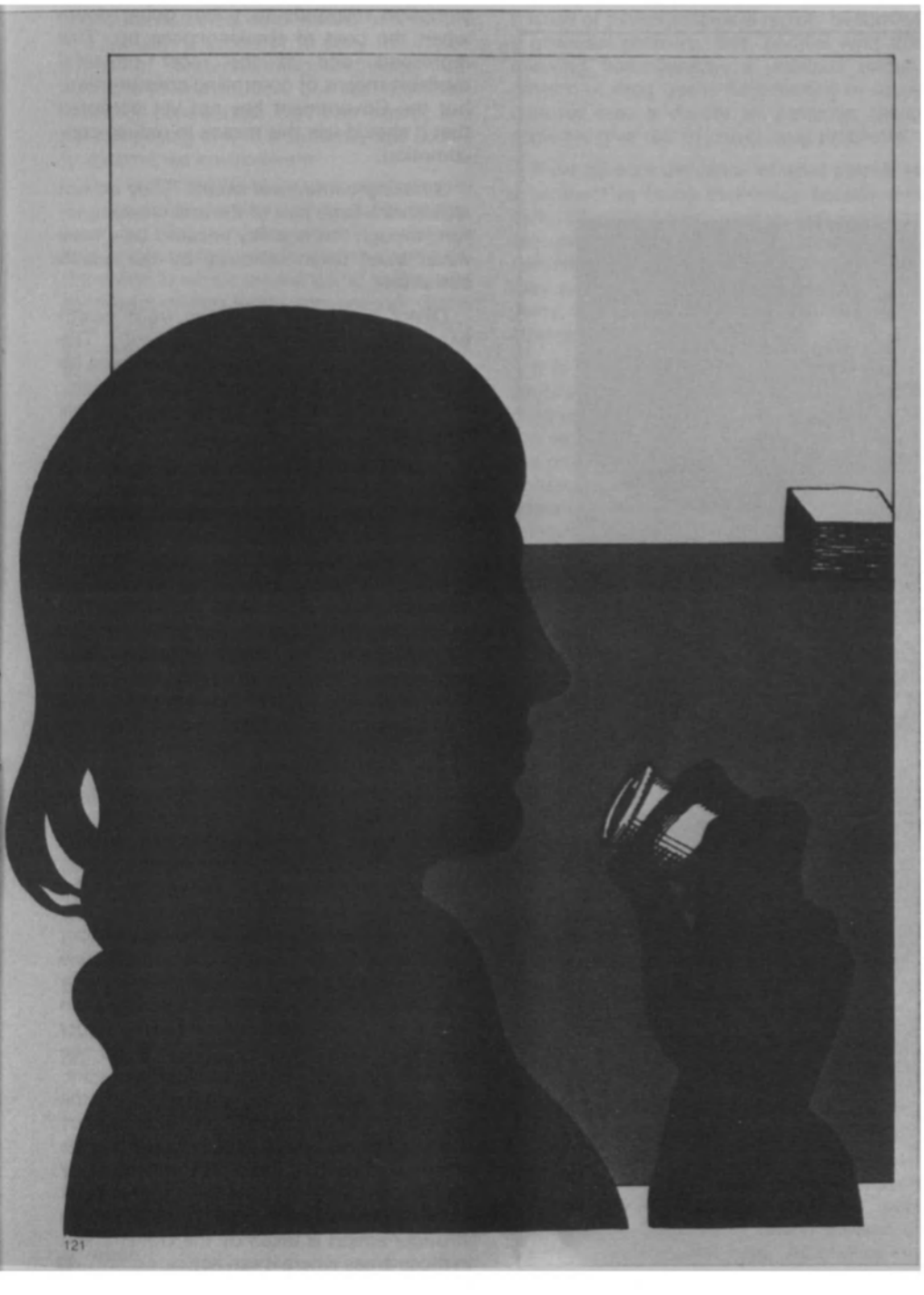
Because of the numbers of people using benzodiazepines over long periods, and because of the issue of limited efficacy and potential damage, it becomes essential to attempt to understand the reasons for these prescriptions. A simple explanation frequently heard is that patients demand them. Research, however, has shown that physicians are more likely to assume that patients want medication than are the patients themselves to want any. Perhaps most important in an understanding of current prescribing patterns is the acceptance by the medical profession of a biomedical view of man. This philosophical view sees the locus of all problems that appear in the physician's office as being within the individual, hence requiring biological solutions.

We might ask what has been done to reorient the concern of both prescribers and consumers to the long-term use of these drugs. Psychotropics represent a special case in that the media and consumer groups seem to have generated as much concern about consumption patterns and consequences of using them as have governments and the medical profession.

A recent issue of the British *Journal of the Royal College of General Practitioners* dealt almost exclusively with prescribing in general practice. The editorial pointed out that the interests of the Government, which pays for drugs, and of the pharmaceutical manufacturers are in conflict and "thus combine to bombard the 25,000 prescribers with ever-increasing pressures to conform to one policy or another". It went on to say "Certainly the use of tranquillizers has been questioned increasingly and it is possible that a prescription for tranquillizers can be regarded as something of a therapeutic failure". Governments have been sensitized to the need for intervention, not only because of escalating costs but also by tragedies such as that which followed the introduction of thalidomide.

Consumer organizations in a number of countries publish magazines that carry extensive information on health services, including drug information. By and large, however, the consumer's voice has not been heard in this respect. Only in recent years have research studies been directed away from the traditional "compliance" studies of drug consumption (which ask why the patient does not take his drugs as ordered by the physician) to studies which start from the consumers' perspective. These studies ask users of health services what they perceive the social and emotional consequences of using tranquillizers to be, and enquire also about physical effects. Consciousness-raising and self-help groups have been proposed as alternatives to tranquillizers. In large cities there are self-help groups to aid individuals who want to break their tranquillizer habit.

There are thus two divergent trends in medical care in developed countries. The first is acceptance of the biomedical model and its implications, leading to chemical solutions to social and personal problems, and the second, the increased questioning of traditional modes of medical care. The latter can be seen in the rejection by many patients of the conventional form of the physician-patient relationship, and by the increased use of non-conventional medicine in the form of acupuncture, herbal medicines, and other methods of healing. The benzodiazepines, represent a symbolic focal point for these two trends, thus raising important issues for all countries. ■



Drawing Milton Glaser © The Overlook Press, New York

No smoking, please

by Martin Raw

IN the United Kingdom, by the time it began to be suspected that smoking was dangerous, it was an established habit in 65 per cent of adult males and 40 per cent of adult females. Since 1973, there has been a slow but steady decline in the prevalence of smoking and in tobacco consumption; as a whole between then and now smoking has become a minority habit for the first time since 1945. A brief list of anti-smoking activities can be divided into seven main categories.

Health education: formal and informal. These efforts have been associated with the publication of research findings and of major reports on smoking and health, the holding of world conferences, the formation in the United Kingdom of the Health Education Council (HEC) and of Action on Smoking and Health (ASH), and formal education campaigns launched by the HEC.

Legislation. The most important legislation in the United Kingdom in this respect was probably the banning of cigarette advertising on television in 1965.

Non-legislative pressure on the tobacco and advertising industries. In spite of pressure on the British Government to introduce legislation on issues such as tobacco advertising, it has consistently resisted such pressure. However, it has attempted to put pressure on the tobacco industry through voluntary agreements.

Social control. The restriction of smoking in public places has become increasingly acceptable to the general public and is becoming commoner in an increasing number of settings including London Transport vehicles (1971), cinemas (1971) and aeroplanes (1972).

Price control. It has been clearly demonstrated that in Britain cigarette consumption responds to price, going down when the cost of smoking goes up. This represents one of the most powerful available means of controlling consumption, but the Government has not yet accepted that it should use this means to reduce consumption.

Smoking withdrawal clinics. They do not represent a large part of the anti-smoking effort, though this is partly because they have never been taken seriously by the health authorities.

Direct anti-smoking advice from health care professionals to their patients. The evidence suggests that this advice could be effective with various groups of patients, the most important being patients of general practitioners.

Once it was established that smoking was dangerous, we were faced with a most difficult problem. The health educators assumed that once they had persuaded the public that smoking was dangerous, people would give it up voluntarily. This assumption proved naive, mainly because it did not take into account and deal with the many other factors that affect smoking. Amongst these were the addictive nature of the behaviour itself and the considerable resources that were being devoted to its promotion. It is absurd that in the United Kingdom the Health Education Council should be in a position to spend only £1,000,000 (2 million U.S. dollars) a year on anti-smoking activities whilst the tobacco industry spends nearly £100,000,000 (200 million U.S. dollars) to promote smoking. Yet the Government has been loath to take any action that might reduce consumption, because, it is presumed, of the considerable revenue it derives from tobacco consumption. It seems all the more remarkable then that some combination of the seven factors described above has steadily reduced the demand for tobacco over the last five years. Although none of the approaches to the control of smoking described here could by itself achieve much (except for price control), collectively and cumulatively they are having an effect. However, they will not solve the smoking problem until much stronger action is taken by the Government in those areas where it can act. ■

MARTIN RAW *is a psychologist at St. George's Hospital, London, and is a specialist in research on smoking.*

A problem in constant evolution

by Griffith Edwards and Awni Arif

IT is impossible to think about, or helpfully respond to, any aspect of drug-taking without at every stage seeing drug-taking (and our responses to drug-taking), in a socio-cultural context. Man or woman abstracted from society and culture is a fantasy. This is not to deny the importance of understanding individual differences in constitution, but the individual, however constituted, can live, move, and have his being only in a culturally and socially determined environment.

This is not the place for an extended essay on futurology but it would be futile to suppose that those who are specially concerned with drug problems could divorce them from the world in which we are going to live, and the future of that world background. Shifts and growth in world resources, new poverty or new wealth, are likely to have a fundamental impact on drug problems and to determine how much money will be invested in drug programmes.

Beyond those external and material aspects of the future, drug use (and response to drug problems) will be profoundly affected by such factors as values; the place accorded the individual in society, in every sense; the value put on freedom and rights to pleasure-seeking; the importance and essential meaning given to health. A concern with these types of question is sometimes dismissed as utopian, but it might be argued that one of the changes we are seeing is a rediscovery that these questions are exactly those which we have a right to ask. If we ignore them, we do so at our peril, and among those perils may be an acceleration in misuse of drugs, or misuse of treatment and preventive actions.

In a world experiencing upheaval and breakdown in old structures and values, much of the long-standing equilibrium between societies and their use of drugs will break down too. In the immediate future the world is likely to experience an intensification of drug-related harm.

There is already a tendency towards world homogeneity in drug use. Cannabis, which until recent decades was largely indigenous to the East, has now become well established in Western societies. Alcohol, which has been so much the traditional drug of the Western world, is now increasingly giving rise to problems in countries of the East. The misuse of psychotropics is rapidly becoming a universal problem. But, parallel with this growing homogeneity, a previous unitary pattern of drug use is fragmenting in many cultures into a variety of patterns: plural societies give rise to plural drug problems.

If we take the definition of what counts as a problem as being essentially socially and culturally determined we may also expect to see profound shifts in the processes of definition. What counts as a problem now may not attract the same definition in ten years; or new definitions of the problem may emerge over that period.

It is possible, for instance, that in recent years we have tended unduly to emphasize drug use itself or the state of dependence as the essential problem, rather than defining the problem more fundamentally in terms of consequent damage. On the one hand, some societies are moving towards a more tolerant view of forms of drug use that are not very harmful but at present disallowed; on the other, cigarette smoking is increasingly being regarded as a problem in terms of the damage it causes. At present, alcohol use is not seen in most countries as a problem in terms of its mere use; it is alcoholism that attracts concern. A movement is under way, however, to define a certain level of alcohol use as a problem for societies, given the probable association between national drinking levels and the amount of alcohol-related damage.

Even where there are no large changes in the definition of problems, there may be alterations in the ordering of problem priorities. For example, a trend may be emerging towards according a higher priority to socially accepted drugs such as alcohol and tobacco or licitly prescribed drugs such as the benzodiazepines, in relation to the traditionally illicit drugs. The dichotomy between policies directed towards licit drugs, on the one hand, and illicit substances, on the other, may be breaking down.

It is evident that in many parts of the world socio-medical help at the most basic level is still lacking for people in trouble with their drug-taking. In many countries, still, people often languish in prison instead of receiving constructive help. Alcoholics die of delirium tremens for lack of the most simple technical knowledge. Much-needed facilities for drug detoxification are lacking. Even the rudiments of rehabilitation are often missing. It must be hoped therefore that one trend for the immediate future will be an energetic effort to ensure that these needs are met and organizational problems tackled.

But, at the same time, care must be taken that the extension of facilities does not mean the cruder extension of the medical model, which conditions the individual to learned helplessness and the community to surrendering its responsibilities. The helping professions must not expect or be expected to take responsibilities for all problems. A response planned in terms of medical care alone would be not only beyond the economic resources of any country, but also likely to be largely ineffective. What is needed rather is the further development of a model that would see treatment as a partnership between the individual, the community and the helping professions, with the helping professions in an assistant role.

Also, it seems likely that over the next decade there will be increasing interest in what were previously deemed to be the non-specifics of treatment: set and expectation, the role and self-definition given, the optimism that is engendered, the goals that are collaboratively defined, the sense of autonomy that can be restored, and the therapeutic relationship. The hope for the future must be more in terms of understanding and developing those processes and less an expectation of wonderful new technologies. There must, of course, be a willingness to explore further the alliance between natural processes that foster and reinforce recovery and active treatment.

With regard to prevention, the same basic theme of the need for congruence between society's response and the socio-cultural context needs to be emphasized as the issue that requires continuous awareness and scrutiny; it must be hoped that this will receive more attention than it has in the past. In some areas, what may be seen is a new balance of investment in overall programmes, with prevention being given higher priority. With regard to alcohol problems, for instance, it seems likely that in some countries there has been too much emphasis on treatment, and that prevention has been neglected.

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Another question, and a disturbing one, is whether some of our present preventive efforts may be doomed to failure, whether action on substance problems may be diversionary activity to excuse our neglect of more profound societal problems that breed the misuse of substances. To take the example of the case study on drinking patterns in Kenya, no one could seriously suppose that Kenya's drinking problems are going to be dealt with by an anti-alcoholism campaign alone. This is not to preach despair or lend support to neglect, but we have to be careful lest society is evading responsibility by focusing unduly and too superficially on drug problems. We come back to daring to be utopian.

Having argued that the cruder application of the medical model can sometimes carry with it learned helplessness so far as the individual's ability to help himself is concerned, one might then examine the parallel argument as regards prevention. Could we expect that communities themselves—people in particular work-places or schools, groups defined by some special shared awareness such as women's groups—would take initiative for their own prevention policies, rather than leave it to the State to do so?

The sense of future that is being developed here in terms of a need to be aware of the relation between wider sociocultural changes and drug use and drug problems, and in terms of changes in definitions of the drug problem and in treatment and prevention, carries the implication of a new research agenda. Without spelling the matter out laboriously it can be said that all the issues raised above are potential issues for research. In practical terms, what one might hope for is some movement away from the dominance of a particular form of epidemiological research on drugs, which, although it has its place, has at times become rather mechanistic and perseverative, with the drug user treated as an object of study divorced from the study of the culture and social institutions.

Whether international effort is mediated through international organizations or by any other process, what is clearly needed is an increased willingness to take account genuinely of experiences of countries other than one's own. It must be hoped that in the future there will be much more open exchange of ideas than has sometimes been seen, with no one dominant cultural view. This is a vital consideration equally for treatment, preventive action (whether dealing with demand or supply) and research.

To listen to other countries' experiences one must, first, be given a chance to hear of those experiences. An enormous amount is being thought about, argued about, and accomplished in many different countries, and further ways of exchanging these experiences are badly needed. Much of WHO's current drug programme is directed to that end. It is to that endeavour that this issue of the *Unesco Courier* also seeks in some measure to contribute.

■ **Griffith Edwards and Awni Arif**

Photo DINEMS/UNESCO/UNFDAC pilot project, Argentina

For teenagers, such feelings as loneliness, inability to communicate with others, and lack of direction or purpose may increase the risk that they will become dependent on drugs. The educational system can help students tackle these problems by organizing in-school activities to break down barriers of communication and to provide various kinds of help and guidance. Unesco and the United Nations Fund for Drug Abuse Control are currently collaborating with the Argentine education authorities in a pilot project along these lines. Photos show pupils at the Vicente López national and commercial college, one of the schools where the project is being carried out, taking part in group activities designed to foster a community spirit. Top left, an "audiovisual message" was used by one group of children to encourage their friends to express their feelings about adolescent life.

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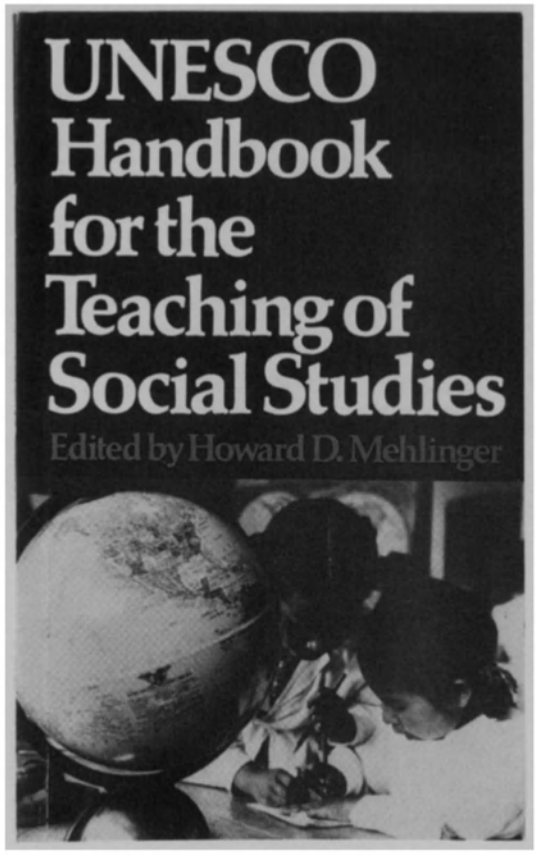

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Through a glass darkly

The perception of drug problems and their treatment varies widely throughout the world according to the values and cultures of different societies. See article page 20 for the work of Alcoholics Anonymous, which was founded in the USA, and of Japan's Alcohol Abstinence Society, as well as other original approaches to the treatment of individuals with a drug problem. Here, a still life by the 17th-century Dutch painter Willem Claesz Heda.